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Necessity Not Choice: Worker and Homeless Adult Perspectives on Shelter Usage

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Necessity Not Choice: Worker and Homeless Adult Perspectives on Shelter Usage

by
Michelle Sveiven Smith, B.S.W

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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Lisa Kiesel, Ph.D., (Chair)
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study.

This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to examine workers and homeless adults' perceptions of barriers that impact homeless adults' utilization of shelters. The theory underlying this study was that shelter safety and capacity issues served as barriers to utilizing shelters. One focus group of workers and six interviews with homeless adults were conducted to learn about perceptions on shelter usage and barriers to shelter usage, shelter alternatives used by homeless adults, risks of not utilizing shelters, and barriers to exiting homelessness. This study found that homeless adults use shelters out of necessity and that safety and capacity are not barriers to use. A variety of factors were found to contribute to homeless adults' decisions on whether to use shelters, including safety, shelter location and environment, shelter rules, and autonomy and dignity. Implications for practice and policy include a need for service providers to understand the tradeoff they are asking homeless adults to make in order to use shelters, the role dignity and autonomy play in service utilization, the need for increased advocacy efforts on behalf of the homeless population, examination of shelter policies and rules, more affordable housing, and increased access to affordable housing.

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Definitions of homelessness vary, and housing program guidelines for what qualifies as an episode of homelessness are often different, depending on whether the program is funded by HUD, the state, or privately. Minnesota's current shortage of affordable housing makes subsidized housing programs, such as those funded by HUD, one of the only options for homeless individuals seeking permanent housing. However, strict guidelines for these programs, and the varying definitions of homelessness, serve as barriers, particularly to chronically homeless, unsheltered individuals tasked with proving homelessness in order to qualify for assistance obtaining permanent housing.

The Minnesota Housing Finance Agency (MHFA) (2011) offers a simplified definition of homelessness as: "A household lacking a fixed, adequate night time residence (includes double up)." Long-term homelessness involves lacking "a permanent place to live continuously for a year or more or at least four times in the past three years" (MHFA, 2011). Individuals are considered to be unsheltered when they are spending the night in locations unfit for habitation, including vehicles, 24-hour businesses, abandoned buildings, and outdoor locations (Wilder, 2013). Informal arrangements, such as couch-hopping, doubling up, or paying for a motel room are alternatives homeless individuals use for temporary shelter (Wilder, 2013). MHFA considers couch-hopping and doubling up with another household for less than a year an episode of homelessness; however, HUD does not (HUD, 2007; MHFA, 2011).

Of the 10,241 homeless individuals in Minnesota on October 25, 2012, almost 22% (2,221) were not staying in a formal shelter or housing program (Wilder, 2013). There are slightly more homeless men (53%) than women (47%) in Minnesota (Wilder, 2013). Adult men aged 22 through 54 were most likely to be unsheltered, followed by adult women in the

same age range (Wilder, 2013). Unsheltered individuals are difficult to count, since they often cannot be found and are transient by nature, but Wilder (2013) estimates an additional 3,875 individuals were unsheltered on any given night in Minnesota in 2012. Racial disparities are prevalent in the homeless population, and though homelessness among minorities has dropped, 55% of homeless individuals in 2012 were African American, American Indian, or Hispanic (Wilder, 2013). Half of the homeless adults in Minnesota had been homeless over a year in 2012, and more than half (55%) had experienced three or more episodes of homelessness (Wilder, 2013).

Minnesota is currently experiencing an affordable housing crisis. The average wait time for subsidized housing in the state is nearly one year, and 41% of Minnesota's homeless population are currently on waiting lists for subsidized housing; an additional 15% report inability to get on waiting lists due to closures (Wilder Research, 2013). According to the Minnesota Housing Partnership (2012b), 94% of Minnesota counties do not have enough available and affordable housing for "extremely low-income residents," and almost half of the counties would need to more than double their current supply in order to meet demands. The recent foreclosure crisis converted many homeowners into renters, creating a growing demand for the limited supply of rental housing available in Minnesota, leading to limited choices and higher rents (Minnesota Housing Partnership, 2012a). Between 2010 and 2011, Minnesota experienced an 18% increase in renter households and a corresponding 1% decrease in rental vacancies (National Alliance to End Homelessness, 2013). In addition, 38 states reported an increase in fair market rents between 2010 and 2011, and Minnesota experienced a 2% increase in fair market rents during the time period (National Alliance to End Homelessness, 2013).

Affordability is the most common reason homeless individuals lost their permanent housing and serves as a barrier to homeless individuals obtaining housing (Harris, 2010; Wilder, 2013). Workers making minimum wage in Minnesota cannot afford to pay fair market monthly rent in any Minnesota county, and according to the JOBS NOW Coalition (2009), 39% of the available jobs in the state pay a lower wage than is required to meet basic needs (as cited in Minnesota Housing Partnership, 2012a). In Minnesota, 38% of adults reported leaving their last permanent housing because they could not afford rent or house payments (Wilder, 2013). The second most common reason homeless individuals in Minnesota provided for losing permanent housing was the loss of a job or work hours (Wilder, 2013). Insufficient income also contributes to the inability of homeless individuals to obtain permanent housing (Harris, 2010). Combined, inability to afford housing costs and loss of job or hours accounted for almost half (46%) of homeless adults in Minnesota (Wilder, 2013).

Without the ability to access affordable, permanent housing, many of Minnesota's homeless individuals and families are left with emergency shelters as their only option. Some homeless individuals choose not to use emergency shelters, whittling their options down to living on the streets or couch-hopping, both of which serve as barriers to exiting homelessness. There is a lack of research examining why some homeless individuals do not utilize shelters, despite the risks and barriers they face living on the streets. This study examines worker and homeless individual's perspectives on shelter usage. A summary review of the literature regarding homeless risks, homeless shelters, the unsheltered, resistance to shelter, and barriers to service utilization is provided. The method for obtaining and analyzing data and insuring protection of human subjects is described in detail. Findings

are presented with quotes from respondents used to illustrate findings, and a discussion on implications of these findings is presented. Finally, strengths and limitations of the study are provided.

Literature Review

Homelessness Risks

Homeless individuals, particularly those who are unsheltered, encounter a variety of risks in their day-to-day lives on the streets including a variety of health issues, engagement in criminal activity, and vulnerability to victimization.

Health. Poor health is both a precursor to and result of homelessness, and a variety of health issues are observed disproportionately among homeless individuals. Individuals experiencing long-term homelessness are more likely to have multiple health problems, severe medical conditions, substance use disorders, and are at greater risk of contracting airborne diseases (Gilderbloom, Squires, and Wuerstle, 2010; Meschede & McCormack, 2004; Wilder, 2013). In Minnesota, 60% of adults experiencing long-term homelessness have a serious mental illness, 54% have a chronic health condition, 26% have a substance use disorder, and 48% have a condition that limits their ability to work (Wilder, 2013).

Physical health. An illness or injury may lead to loss of employment after the injured individual is forced to miss too much time from work, uses up available paid time off, or is unable to perform work functions or maintain a stable schedule (National Health Care for the Homeless Council (NHCHC), 2011). Losing employment often means losing health insurance, creating a “downward spiral” in which the individual is without funds to pay for health care, so the individual cannot heal and work again (NHCHC, 2011). Loss of income from employment also leads to the loss of housing, which when combined with no income,

poor health, and lack of social support, leads to homelessness (NHCHC, 2011).

Homeless individuals have disproportionately high rates of both acute and chronic illnesses when compared to non-homeless individuals (NHCHC, 2011). Recovering and healing from injuries and illnesses is nearly impossible without stable housing (NHCHC, 2011). Homeless individuals have a higher risk than the general population of developing exposure-related conditions, such as hypothermia and frostbite, that can be life threatening and permanently damage health (NCH, 2010b). The use of substances such as alcohol, nicotine, some medications, and street drugs, and chronic problems faced by the homeless such as malnutrition and inadequate clothing, increase susceptibility to hypothermia (NCH, 2010b).

Mental health. A large portion of adults with mental illness are homeless, and mental health issues serve as a barrier to exiting homelessness. On any given night in January 2010, 26.2% of homeless individuals in the United States had a severe mental illness, and approximately 30% of chronically homeless individuals in the United States have mental health conditions (SAMHSA, 2011). Post-Traumatic Stress Disorder (PTSD), an anxiety disorder, is prevalent among homeless individuals and is observed especially in homeless veterans. Traumatic events experienced during homelessness may lead to PTSD, as can the event of becoming homeless (HCH, 2000). While few people with a serious mental illness require institutionalization today, promises of the creation of outpatient, community-based mental health services during the deinstitutionalization movement have not been fulfilled to the degree needed, resulting in approximately 40% of individuals suffering with a mental illness lacking the treatment they need and many of these individuals being detained in jails and prisons (HCH, 2000). Severe and persistent mental illnesses (SPMIs) include

schizophrenia, bipolar disorder, major depression, and dementia, and individuals with SPMI are more likely to refuse treatment and medication (HCH, 2000). In addition, SPMI can impair judgment and the individual's "capacity to make appropriate behavior decisions (HCH, 2000, p. 1)," making homeless adults with an SPMI more vulnerable than other homeless adults and increasing the likelihood that they will be exploited, will experience victimization while homeless, and will experience prolonged homelessness (HCH, 2000).

Chemical health. Substance abuse can be both a cause and result of homelessness. The co-occurrence of substance abuse with mental illness is common, especially among the homeless population, as individuals with untreated mental health issues often use substances to self-medicate (NCH, 2009). Some homeless adults self-medicate with alcohol and drugs to relieve the stresses of living on the streets, and those who developed substance abuse issues prior to losing their housing, will likely continue using after becoming homeless (Didenko & Pankratz, 2007; HCH, 2000). Substance use disorders often lead to homelessness, as they increase the risk of social isolation due to disruptions in social relationships, financial difficulties, health issues, job loss, violence, poverty and other hardships (NCH, 2009; HCH, 2000). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), on any given night in January 2010, 34.7% percent of sheltered homeless adults had chronic substance use issues and approximately 50% of chronically homeless individuals in the United States had a co-occurring substance use problem in 2010. Breaking an addiction may be especially difficult for homeless adults who are more focused on survival than drug counseling and may have low motivation to stop using, especially if drugs and alcohol are used to cope with being homeless (NCH, 2009).

Crime. Engagement in criminal activity is often a survival mechanism of homeless

individuals, and the presence of a criminal record serves as a barrier to obtaining permanent housing. Unsheltered and longer-term homeless individuals were more likely to commit non-violent offenses, including trading sex for money or other goods, burglary, shoplifting, public disturbances (urinating in public or public intoxication), and check fraud in order to meet survival needs (Fischer, Shinn, Shrout, & Tsemberis, 2008). Sheltered homeless were less likely to commit such crimes, presumably because the institutional support provided by shelter lowered the need for these individuals to perpetrate crimes to meet survival needs (Fischer et al. 2008). Both men and women reported engagement in theft and panhandling; however, women were more likely to engage in prostitution and shoplifting, and men were more likely to engage in selling drugs (Evans & Forsyth, 2004). Sheltered homelessness was associated with an increase in violent crime while unsheltered homelessness was not related to violent crime (Fischer et al., 2008). Fischer et al. (2008) posited some homeless individuals might become violent when in temporary living situations, such as shelters, because such environments increase contact between individuals who are already experiencing high levels of stress from being homeless and the atmosphere at shelter may create “confrontational living conditions that lead to violence” (p. 262).

Victimization. Many homeless individuals who cannot secure overnight shelter must find alternative arrangements and are often limited to public, outdoor locations, leaving these unsheltered individuals particularly vulnerable to victimization. Homeless individuals experience victimization at a higher rate than the housed (Garland, Richards, & Cooney, 2010). The unsheltered are more likely to report victimization, likely as a result of forced reliance on open air spaces and camps that are highly visible, unsafe, and leave the individual exposed to surrounding dangers with nowhere to escape the hazards of the street (Garland et

al., 2010; Kohm, 2006). Snow, Baker, and Anderson (1989) found that the risk of a homeless individual being victimized by another homeless individual is high (as cited in Garland et al., 2010), which should not be a surprise given the previously discussed risk of homeless individuals engaging in crime. Though many cities attempt to mediate the influence of high-crime areas through the selective placement of shelters, many shelters are located in urban and inner city areas prone to higher levels of crime, which increases risk of victimization (Donley & Wright, 2012; Lee & Price-Spratlen, 2004; Kohm, 2006).

A homeless individual is more likely to be attacked the longer he or she has been homeless (Wilder, 2013). Kohm (2006) found that cyclical payments of social assistance increased the likelihood of predatory victimization, such as robbery, of those receiving assistance. Men were more likely to report being victims of assault and robbery while women were more likely to experience sexual abuse victimization, and both men and women have reported being victims of theft (Evans & Forsyth, 2004). In Minnesota, 19% of homeless adults reported being sexually or physically assaulted, and 11% had to seek medical care for illness or injury resulting from the attack (Wilder, 2013). Having committed a crime since becoming homeless had a larger impact on increasing the odds of victimization, but being turned away from shelter also increased odds of victimization (Garland et al., 2010).

Gilderbloom et al. (2013) reported individuals experiencing homelessness are at a greater risk of engaging in “conflicts with strangers who might have a criminal past” (p. 31). In addition, hate crimes perpetrated by the housed against the homeless population are also an issue. The National Coalition for the Homeless (NCH) (2012) documented 1,289 hate crimes against homeless persons from 1999 to 2011. While most incidents are non lethal, 339 victims lost their lives between 1999 and 2011 (NCH, 2012). The relative ease of targeting

homeless individuals who live in public spaces and bias against homeless individuals were believed to be the perpetrators' motivation (NCH, 2012). Middle-aged homeless men were the most common victims (NCH, 2012; Wilder, 2013), which is to be expected, since they are the most likely to be unsheltered. Many attacks including beatings, rapes, assault with a deadly weapon, police brutality, murder, and even setting people on fire go unreported or are forgotten due to the poor treatment of the homeless by society (NCH, 2012).

Homeless Shelters

Few shelters provide the services most needed by homeless adults, and shelter is not always available to those who need it. Emergency shelters offer a safe place to sleep and usually include shower and toilet facilities; some may provide housing information and meals (Wilder, 2013; Gilderbloom et al., 2013). Homeless individuals have a multitude of complex needs that often are not addressed by emergency shelters including housing, income, employment, physical and mental health care, drug and alcohol services, and food (Harris, 2010; Freund & Hawkins, 2004). Chronically homeless individuals with disabilities and co-occurring disorders could also benefit from assistance with the social security disability process and third party payee assistance (Donley & Wright 2012), which usually is not provided by homeless shelters. Though they are designed to provide temporary shelter, some homeless individuals utilize emergency shelters as a long-term solution to their lack of housing (Kohm, 2006).

Lack of available space, staff shortages, curfew, and prohibition of substance use and intoxication were identified as reasons homeless individuals were turned away from shelter (Garland et al., 2010; Harris, 2010). Transgender individuals are at risk of being turned away from shelters due to prejudice or because shelters feel unable to accommodate them (Mottet

& Ohle, 2006). As temperatures drop in winter, many homeless individuals living on the streets turn to shelters to escape the cold, resulting in an influx shelters are unable to accommodate and necessitating turning away some homeless individuals seeking shelter (Donley & Wright, 2012; NCH, 2010b). In January 2013, 65% of the homeless population across the nation was residing in emergency shelters or transitional housing, leaving 35% unsheltered (Henry, Crotes, & Morris, 2013). About one in five homeless adults in Minnesota were turned away from shelter in the three months prior to October 2012 (Wilder, 2013), indicating that shelter capacity is also an issue during warmer weather months. Of those, three-quarters ended up doubled-up, in cars, outdoors, or in other places not fit for habitation (Wilder, 2013).

Resistance to Shelter

Though there is a lack of research regarding reasons some homeless individuals do not utilize shelters, the few studies that speak to this issue are revealing. Restrictive policies governing the number of occupants at shelter and the length of stay (most shelters are generally open evenings and overnight, leaving homeless individuals without daytime shelter) eliminate shelter as an option for some homeless individuals (Gilderbloom et al., 2010; NCH, 2010a; Wilder, 2013). Restrictive admissions policies barring individuals exhibiting severe symptoms of mental illness and serious physical problems offer an additional barrier to accessing shelter (Wong, Park, & Nemon, 2006). In addition, crowds, unsanitary conditions, lack of privacy, lack of handicap accessibility, and beds ill-equipped to handle individuals with disabilities are problems encountered by those utilizing emergency shelters (Gilderbloom et al., 2010; Meschede & McCormack, 2004; NCH, 2010a). Themes found to contribute to lack of shelter utilization included location and safety of facilities,

prior negative experiences, companionship, and freedom or preservation of independence (Donley & Wright, 2012; Harris, 2010; Meschede & McCormack, 2004).

In regards to safety, stories about the threat of theft at shelters seemed to be common among the homeless population (Donley & Wright, 2012). Donely & Wright (2012) found that many homeless individuals felt safer in camps, often due to the protection provided by their group, and viewed camps as more comfortable, quiet, and peaceful than shelters. Chronically homeless individuals felt free and in control of their lives on the streets, making shelter environments with restrictive policies and procedures unappealing (Donley & Wright, 2012; Farrell, 2010).

Separation from companionship, due to policies that segregate genders in different sleeping quarters and that bar companion animals, was also cited as a reason homeless individuals opt out of shelters (Donley & Wright, 2012; NCH, 2010a). Gender segregation policies also present a challenge for transgender individuals, who are overrepresented in the homeless population due to difficulties maintaining housing, such as rejection of family members that leads to being kicked out of the home and discrimination of landlords and housing providers (Mottet & Ohle, 2006). Shelter policies in which physical anatomy dictates with which gender an individual is placed are insensitive and put the transgender individual in an uncomfortable and possibly unsafe position (Mottet & Ohle, 2006). In addition, shared shower and toilet facilities may expose an individual's transgender status, depriving them of the control over who knows about their status and exposing them to the danger of verbal harassment and physical assault (Mottet & Ohle, 2006).

The Unsheltered

When turned away from shelter and unable to find appropriate shelter, many homeless individuals turn to camping outside. Homeless encampments exist around the nation and vary from makeshift camps to larger tent cities with populations ranging from a few to hundreds of homeless individuals (Donley & Wright, 2012). Camps are most often dominated by the chronically homeless, and drinking and drug problems, mental health diagnosis, and physical disabilities are reported issues faced by individuals residing in camps; multiple disabilities are also common (Donley & Wright, 2012). Despite these issues, lack of economic resources, such as jobs and money, were reported to be the primary reason campers were homeless (Donley & Wright, 2012; Kohm, 2006). In addition, campers reported they were homeless by choice or because of personal failings, and expressed a desire to simply be left alone (Donley & Wright, 2012).

An examination of smaller homeless camps in Florida consisting of five or six individuals revealed social structures within camps and a sense of community among the homeless (Donley & Wright, 2012). A sense of companionship and kinship, which provided a source of comfort and support, seemed to exist among those living in similar circumstances (Donley & Wright, 2012; Kohm, 2006). Social structures in camps developed quickly and typically included someone in charge and group rules; rules against theft and respect for the security and belonging of others were common (Donley & Wright, 2012). Safety concerns with law enforcement were cited as a concern of homeless campers who reported numerous arrests for matters they perceived to be trivial (Donley & Wright, 2012). Regulations against squatting and tent cities exist in about one-third of North American cities (Gilderbloom et al., 2013), indicating that the fear of law enforcement is not unfounded.

Barriers to Service Utilization

The research illustrates several barriers the homeless population encounters when attempting to access basic needs, social services, and housing services. Lack of awareness of benefits, lack of knowledge on where to seek assistance, inability to complete paperwork, and long wait times to access services prevented homeless individuals from engaging in services (Donley & Wright, 2012; Harris, 2010). Further, Freund & Hawkins (2004) found a number of Pennsylvania's unsheltered homeless did not believe they were eligible for services they needed, leaving them no choice but to survive on the streets. Fear of service providers and perceptions that providers are not supportive and do not understand them were common among homeless mothers (Szandjder-Murray & Slesnick, 2011). In addition, Meschede and McCormack (2004) found that service providers and street homeless disagreed on needs, with providers focusing more on service needs and homeless individuals placing emphasis on needing housing options.

Individuals with substance abuse issues who are not interested in drug or alcohol treatment were resistant to utilizing shelters and other services that may compel them to engage in treatment (Donley & Wright, 2012). Detoxification was the most commonly used form of treatment for chronically homeless with substance use issues, and individuals often left detoxification without referral to additional treatment or services, which may lead to a belief among chronically homeless individuals that there are no effective treatment programs available to them (Freund & Hawkins, 2004; Meschede & McCormack, 2004). Completing treatment without receiving aftercare and access to housing resulted in relapse for individuals with substance use disorders who were often forced back to the streets where drug use is prevalent (Freund & Hawkins, 2004).

In American culture, differences such as poverty and homelessness are viewed as problems, leading to discrimination, prejudice, social exclusion and stigmatization of the poor and homeless (Belcher & DeForge, 2012). The homeless are blamed for their unfortunate situations as the focus is often on personal failings society views as avoidable, such as alcohol and drug abuse, rather than societal causes, such as poverty (Belcher & DeForge, 2012). Social service providers' view of homeless individuals as clients contributes to stigmatization, as homeless individuals are viewed as dependent upon others for their care (Belcher & DeForge, 2012).

The heavy self-reliance developed by those living on the streets can make receiving assistance from others challenging (Harris, 2010). In addition, psychological barriers including hopelessness, lack of self-esteem, and fear of change and the unknown make leaving the streets difficult for the chronically homeless (Meschede & McCormack, 2004). For the chronically homeless, life on the streets becomes familiar and normal, so attempts to leave the streets may result in unconscious resistance that manifests as avoiding outreach workers and sabotaging appointments (Farrell, 2010). Further, the comfort of living on the streets makes structured settings uncomfortable, and the chronically homeless may experience difficulty living indoors, following rules, and anxiety, restlessness, and feelings of powerlessness when confined to an apartment or room (Farrell, 2010; Meschede & McCormack, 2004).

Harris (2010) found that many policies and procedures are based on definitions of homelessness created by service providers and policy makers who have never experienced homelessness, which impacts provision of services. According to HUD, a chronically homeless individual is “an unaccompanied individual with a disabling condition” who has

either been “continuously homeless for one year or more, or...has had at least four episodes of homelessness in the past three years.” (HUD, 2007, p. 3). HUD provides grants to programs implementing housing and services for the chronically homeless population.

Long waits for housing and complex application processes serve as additional barriers to accessing permanent housing (Meschede & McCormack, 2004). Freund and Hawkins (2004) found that HUD services are difficult to access when needed. Homeless individuals applying to a HUD funded program must verify their eligibility, and at the time of entry into a HUD program, an individual must have been living in an emergency shelter or a place unfit for human habitation (HUD, 2007). As was previously mentioned, individuals who are couch hopping do not meet HUD’s eligibility criteria, nor do those utilizing transitional housing (HUD, 2007).

Because written third party verification signed by homeless shelter providers, outreach workers, or other homeless service providers is required to document chronic homeless eligibility for HUD programs (HUD, 2007), many unsheltered individuals who rely on couch-hopping or who live on the streets are tasked with proving homelessness in order to demonstrate eligibility for housing programs. One the easiest ways to prove homelessness is utilizing an emergency shelter; however, many of Minnesota’s homeless individuals appear to not utilize emergency shelters for one reason or another, putting themselves at risk of being ineligible for housing programs meant to help them get off the streets. This study will examine why some homeless individuals do not utilize emergency shelters. This study seeks to answer the question: what are the barriers perceived by workers and homeless adults that impact utilization of emergency shelters?

Conceptual Framework

Knowledge of the theories or lenses that shape research provide context and help avoid bias. I employ Milburn & D'Ercole's (1991) stress model, Miller and Keys' (2001) understanding of the impact of dignity on the experience of homelessness and service utilization, and Hopper, Bassuk, and Olivet's (2010) trauma-informed care framework in this study. As a researcher and social worker, I am also aware of how my professional experience may influence this study. This section will conclude with a reflection on my professional lens.

Stress Model

By most standards and definitions, homelessness is a highly stressful event. Both acute and chronic events, and interaction of the two, may lead to stress (Milburn & D'Ercole, 1991). In addition, acute events may exacerbate or intensify chronic stressors (Milburn & D'Ercole, 1991). Many of the stressors presented by ongoing homelessness, including housing instability, poverty, and victimization, also culminate in homelessness (Milburn & D'Ercole, 1991). Lack of discretionary income is a result of poverty and contributes to an inability to afford necessities, including housing. Housing instability, in turn, often leads to homelessness and results in chronic homelessness or cycling in and out of homelessness (Milburn & D'Ercole, 1991). Physical and sexual abuse, and particularly domestic violence, may lead to social isolation that makes women in particular vulnerable to homelessness, and the long-term effects of such victimization impact the woman's ability to cope with and free herself from homelessness (Bassuck & Rosenberg, 1988, as cited in Milburn & D'Ercole, 1991; Evans & Forsyth, 2004). Other stressors that contribute to homelessness include marital disruption, economic and emotional dependency, criminal activities, lack of employment, and injuries from accidents (Evans & Forsyth, 2004). Social support and coping

skills are important mediators to stress that may also assist with ending homelessness (Milburn & D'Ercole, 1991).

Trauma-Informed Care

In addition to serving as a stressor, homelessness may be viewed by some as a traumatic experience, and as discussed in the literature review, homelessness increases the risk of trauma in the form of victimization. Many of the stressors that contribute to homelessness, such as domestic violence, physical and sexual abuse, and accidents, are in themselves traumatic. A defining feature of trauma is that it overwhelms the individual's ability to cope (Hopper et al., 2010). In addition, long-lasting impacts of trauma interfere with the individual's perception of self-efficacy and control, ability to regulate affect, sense of self and safety, and interpersonal relationships (Hopper et al., 2010), all of which may negatively impact the individual's ability to free him or herself from homelessness. Thus, without addressing trauma underlying the experience of homelessness, the issue of homelessness itself cannot be addressed (Hopper et al., 2010). Trauma-Informed Care (TIC) is a strengths-based approach that incorporates understanding of trauma, emphasizes safety, and offers the opportunity to rebuild control and a sense of self-efficacy (Hopper et al., 2010). TIC has been shown to have a positive effect on housing stability, greater collaboration between providers and consumers, and a greater sense of safety among individuals served by TIC providers (Hopper et al., 2010).

Dignity

The dignity of homeless individuals may be compromised by the ways in which society and service providers treat them. Society's typical avoidance or ignorance of homeless individuals undermines their dignity. In addition, homeless individuals often

encounter restrictive rules, long waits, lack of privacy, and negative or impersonal treatment at shelters, all of which erode dignity and undermine self-determination. The invalidation of dignity has been linked to lack of self worth, anger, and depression (Miller & Keys, 2001).

Environmental events that validate and invalidate dignity impact the experience of the homeless population and their engagement in services (Miller & Keys, 2001). Events that invalidate dignity include arbitrary or excessive rules, lack of basic needs resources, and shelter facilities that are inadequate or dirty (Miller & Keys, 2001). The invalidation of dignity experienced at shelters may be a reason some homeless individuals choose to avoid shelters.

Events that validate dignity include being treated like a human being, sense of belonging, personal service, and receiving care, support, and encouragement from others (Miller & Keys, 2001). Resources that increase self-sufficiency, meet basic needs, and allow the individual to participate in their community also promote dignity (Miller & Keys, 2001). Individuals whose dignity is validated feel worthy and motivated and have an increased sense of self-worth (Miller & Keys, 2001), which can be expected to assist the individual with exiting homelessness.

Professional Lens

Awareness of what I bring to this study as a professional is just as important to examine as the theories that may impact this study. My Bachelor's Degree in Social Work and former position as a short-term intensive case manager in a community mental health agency will also influence this project. In my former position, I often encountered and worked with long-term and chronically homeless adults and adults at risk of homelessness. My previous experience was influential in my decision to examine shelter utilization by

homeless adults through this research project.

In my previous experience, I have encountered homeless adults and adults at risk of homelessness who refuse to utilize homeless shelters. Risks to safety were often reported to me as a reason some individuals did not want to utilize shelter. Women have expressed fears of being physically or sexually assaulted, or both, and men have expressed fears of having their belongings stolen. In addition, I had a male to female transgender client who refused to utilize homeless shelters because of their gender segregation policies, which would mandate that she stay with the men, which caused her discomfort and fear that she would be harassed or assaulted.

My professional practice has also provided experience in how difficult it is for homeless individuals to extricate themselves from homelessness. Lack of housing resources, including affordable housing and subsidies, and restrictive guidelines of programs meant to help the homeless to obtain housing serve as barriers to permanent housing for some homeless adults. In addition, I have observed the pervasive impact homelessness has on the rest of the individual's life. Without basic needs, such as shelter, it is nearly impossible for an individual to focus on improving or maintaining physical and mental health, obtaining or maintaining employment, engaging in substance abuse or other needed treatment, or even to manage money, all of which contribute to ongoing homelessness.

Methods

Research Design

This was a qualitative study utilizing a modified analytic induction approach. In addition to being an approach to collect and analyze data, analytic induction is a way to develop and test theory (Bogdan & Biklen, 2003). As a qualitative research technique,

analytic induction involves the comprehensive examination of a number of cases to provide generalizations (Scott & Marshall, 2009). Donald Cressey used this methodology in his book *Other People's Money* (1953), and describes the stages of analytic induction as: “defining the field; hypothesizing an explanation; studying one case to see if it fits the facts; modifying the hypothesis or the definitions in the light of this; and reviewing further cases” (Scott & Marshall, 2009). Re-defining the observed facts and re-forming the hypothesis are continual throughout the examination process until a “universal relationship is established” (Scott & Marshall, 2009). Rather than developing a theory as data is collected, which is typical to the analytic induction approach, this study began with a theory. The working theory for this study was that unsheltered homeless adults do not use homeless shelters because they fear for their safety and that there are an inadequate number of shelter beds available to accommodate the homeless population, resulting in some being turned away from shelters. This theory was tested and refined by the data collected for this study. Unlike a typical analytic induction approach, participants who do not fit this theory were not sought, due to the fact that a convenience sample was used; however, during data analysis, attention was given to themes that are counter to this theory in order to build upon or refute the existing theory.

Sample

Both workers and homeless adults were asked to participate in this study. This researcher's goal was to recruit at least twelve workers and six homeless adults for this study.

Workers. Workers were recruited at a meeting attended by homeless shelter and outreach workers from a variety of agencies that offer services to homeless adults in Minneapolis, Minnesota, making this a purposive sample. The researcher read a recruitment statement (Appendix A) at the beginning of the meeting and requested that interested

workers take a flyer (Appendix B) with researcher's contact information and contact researcher in order to receive an invitation to a focus group. Three possible participants contacted researcher and expressed interest in participating in a focus group.

Since enough workers were not recruited from the meeting for homeless service providers, workers at a community mental health agency were asked to participate. This organization was chosen because this researcher was formerly employed there and was familiar with the setting, services provided, and population served, making these workers part of a convenience sample. One of this researcher's committee members is currently employed at the community mental health agency and sent researcher's recruitment flyer (Appendix B) via email to all workers at the agency, making these workers part of a convenience sample. Three possible participants contacted researcher and expressed interest in participating in a focus group.

Participants for the homeless workers focus groups were selected based on the following criteria: one year or more of experience in direct practice working with the homeless population in non-administrative roles. When the researcher had setup locations, dates, and times for two possible focus groups, individuals who had expressed interest in participating in a focus group and who met this criteria were sent an email (Appendix C) with the possible dates, times, and locations of focus groups and were asked to RSVP to the researcher with which date and time they would like to attend. This email was sent to all six possible participants who had expressed an interest in participating in a focus group. Four responded that they would attend the second group that had been scheduled, one did not respond, and one was unable to attend either focus group option. Three respondents attended the focus group on the scheduled date. All three participating workers were white females.

Participant A had over 10 years of experience working with the homeless population in a variety of settings including detox centers, housing programs, and mental and chemical health programs. Participant B had five years of experience working with the homeless population as an Independent Living Skills (ILS) worker and a housing support specialist. Participant C had 15 years of experience working with the homeless population as a social worker for a program that provides healthcare for the homeless population.

Homeless adults. During the recruitment process for workers, workers were asked to refer homeless adults to participate in this study. Workers were asked to provide researcher's telephone number to homeless adults so that interested individuals could contact researcher for information. Researcher received no referrals utilizing this snowball sampling method, so a convenience sample of homeless adults was recruited at a drop-in center at the community mental health agency from which some workers were recruited. In order to utilize the drop-in center, participants must have a diagnosed serious and persistent mental illness (SPMI) and be receiving care from a mental health professional.

Homeless individuals selected to participate in this study were required to be age 18 or older and to meet the Minnesota Housing Finance Agency's definition of long-term homelessness: "lacking a permanent place to live continuously for a year or more or at least four times in the past three years" (MHFA, 2011). Workers at the drop-in center identified potential participants who met the criteria for the study. Researcher read a recruitment statement to potential participants (Appendix D), and interviews were conducted on-site the same day participants were recruited.

A total of six homeless adults, one woman (17%) and five men (83%), participated in individual interviews. Most participants identified as African American or African American

and American Indian (83%) and one identified as white (17%). The average age of participants was 45.5; all fell into the 32 to 55 age range. On average, participants' most recent bout of homelessness was eight years, and many had experienced a number of periods of homelessness throughout their lives. All participants reported having stayed in a shelter on the evening prior to the interview. Researcher asked each participant to share the top reason they were homeless, and answers varied widely among participants. Lack of family, mental illness, job loss and inability to find or hold a job, domestic abuse, physical disability, lack of affordable housing, and lack of money were all mentioned as reasons for homelessness. Participants identified limited income and lack of affordable housing as the reasons they continued to remain homeless.

For the purposes of this paper, participant's names have been changed to protect their privacy. Respondent 1, "Jerome," a 45-year-old African American male, had been homeless over 20 years with the exception of periods of incarceration. Respondent 2, "Andrew," a 32-year-old white male, had been homeless continuously for almost one year and had experienced at least four periods of homelessness over the last three years. Respondent 3, "Angela," a 55-year-old female who identified as native and black, had been homeless continuously for over one year. Respondent 4, "Marcus," a 45-year-old African American male, had been homeless at least four times over the past three years and was homeless at the time of his interview. Respondent 5, "Ernest," a 50-year-old African American male, had been homeless continuously for eight years at the time of the interview. Respondent 6, "Marvin," a 46-year-old African American male, had been homeless continuously for 14 years at the time of his interview.

Protection of Human Subjects

Participants selected for the worker focus groups were provided a consent form that was approved by the St. Catherine University Institutional Review Board (IRB) in order to insure their protection (Appendix E). The consent form explained the background and voluntary nature of the study, the risks and benefits of participation, and how participants would be protected from harm through confidentiality procedures. Participants had the freedom to cease participation at any time, and questions designed to guide the focus group discussion were nonthreatening and not personally sensitive in nature. Due to the nature of focus groups, it was impossible for the researcher to promise that none of a participant's comments would be repeated outside of the group. Participants in focus groups were notified of the researcher's limited ability to protect confidentiality, and the researcher encouraged participants to keep each other's comments confidential.

Any information that could identify participants was removed from the data used in this study. Finally, all data including the electronic audio recording of focus group proceedings and resulting verbatim transcripts were kept on a password-protected computer accessible only to the researcher and the researcher's chairperson. A transcription service was used to transcribe the audio recordings, and the transcriber signed a confidentiality form (Appendix F) and agreed to destroy data once it had been provided to the researcher. The researcher will destroy electronic audio files and transcripts upon completion of this project on May 18, 2015.

Protection of homeless adult participants was given top priority, due to the vulnerability of the population of adults experiencing homelessness. A research proposal was reviewed and approved by the research committee and the St. Catherine University IRB prior to any contact with perspective participants. The purpose of the IRB was to ensure the

protection of human subjects in this research study. In an effort to protect participants from undue psychological or emotional distress during interviews, the wording used in interview questions and the order of questions were taken into consideration. The researcher also informed participants that they could choose to skip or not answer any question for any reason.

Documentation of the consent process may be waived when “the principal risks are those associated with a breach of confidentiality concerning the subject's participation in the research, and the consent document is the only record linking the subject with the research.” (Hicks, 2011). As such, this researcher requested a waiver of informed consent documentation for homeless adult participants, because homelessness is a stigmatizing condition, a consent document would be the only record linking participants to this research, and a revelation of the individual’s participation in this research would have violated the individual’s right to privacy. Further, many homeless adults are mistrustful of unknown individuals and would thus be unlikely to sign an informed consent document, which may have resulted in a lost opportunity for hearing and presenting the voices of homeless adults. The researcher’s request was granted by the IRB.

In lieu of documentation of informed consent, the researcher verbally discussed background information, procedures, risk and benefits of participation, and confidentiality with each participant and provided each participant a copy of the informed consent information (Appendix G). The researcher stressed the voluntary nature of the study by informing the participants they could skip questions or stop the interview at any point. The researcher verbally acknowledged that she understood that the experience of homelessness is difficult to discuss and may present some discomfort. After the researcher finished reading

the informed consent information to the participant, the participant was asked to explain in their own words what the researcher had told them and what she was asking them to do. This was done for the researcher to assess whether a participant was unable to give consent because they were intoxicated, experiencing a mental health episode, or were exhibiting other signs that lead the researcher to believe the participant was incapable of consent.

For his or her participation, each participant was given a \$10 Metro Transit Bus Pass. The bus pass was presented prior to the start of the interview to ensure participants received this incentive regardless of the amount of the interview they completed. In addition, the participants were encouraged and coached by the researcher to utilize their existing services and providers to process the interview, if they experienced any difficulty, and were provided with a free resource list (Appendix G) prior to the start of the interview. Participants were informed that the information they provided would be kept confidential, would not be linked to their identity, that their identity and participation in this research would not be revealed, and advised that they may discuss the interview with providers and others at their discretion. The researcher obtained verbal consent from the participant that the participant was willing to complete the interview and be audio recorded. One perspective participant did not agree to complete the interview and be audio recorded; this individual was offered the opportunity to complete the interview as a survey, which he also declined. The researcher thanked the perspective participant for his time, and the individual left the interview room.

To maintain the privacy of homeless individuals who might be recruited by workers in this study, the workers were asked to introduce the researcher to possible subjects or to provide her contact information to subjects who may be interested in participating, rather than providing the researcher with the participant's contact information. Participants

recruited at the drop-in center were informed that their participation in this study would not impact their relationship with the drop-in center. In addition, participants were asked if they felt coerced or in any way forced to participate in this research. All participants answered that they did not feel coerced or forced to participate in the study by completing the interview with the researcher.

Data Collection

Focus groups. Focus groups were conducted in a conference room at a public library located in Minneapolis. Two focus groups were scheduled, but only one was held due to lack of participants and because all available participants selected the same focus group date and time option. Four participants were scheduled to attend the focus group, but only three actually attended. Prior to the start of the focus group, participants were asked to read and sign the informed consent document (Appendix E), and the researcher inquired whether any participants had questions before the group started. The focus group meeting was one hour and five minutes in duration, and the discussion was audio recorded. The focus group was semi-structured, as the discussion was moderated using a predetermined list of questions (Appendix H) prepared by the researcher. The researcher used prompts and additional questions as needed to keep the discussion flowing and to clarify information provided by participants.

Individual interviews. Researcher spent two days at the drop-in center conducting interviews. Individual interviews of homeless adults were conducted on-site in empty office space at the drop-in center from which individuals were recruited. Participants were informed they were allowed to leave at any time and were provided the bus pass and informed consent document and free resource list (Appendix G) prior to the start of the interview to ensure they

received these incentives regardless of how much of the interview they completed. The interview began after the researcher has verbally presented and discussed confidentiality information with the participant and the participant had verbally agreed to be interviewed and audio recorded.

Interviews were audio recorded and were semi-structured using a predetermined list of questions (See Appendix I) prepared by the researcher. In addition to providing demographic data, participants were asked to answer questions about their history of homelessness, experience of homelessness, and experience utilizing shelters and other services. The researcher used prompts and asked additional questions as needed. The researcher acknowledged that flexibility might be needed, depending on the individual participant's ability to fully complete the interview. To accommodate this factor, the researcher had identified priority survey questions and listed them first on the survey to ensure the most important data was captured within the timeframe allotted for the interview. The researcher was also willing to maintain flexibility in timing of the interview, allowing participants to end the interview at any time before the 45 minutes were up, and the researcher was also willing to conduct longer interviews of up to 90 minutes to accommodate participants who had more to share. Completed interviews ranged from 20 to 45 minutes in length. The researcher took field notes during the interviews in order to record observations of the participant's ability to comprehend and answer the interview questions, to assist with describing the sample, and to assist with interpretation of interview data.

A transcriber hired by the researcher transcribed the audio recordings of focus groups and individual interviews verbatim. The transcriber was asked to sign a confidentiality agreement (Appendix F). Audio recordings and transcripts of the focus group and each

interview were kept on a password-protected computer only accessible to the researcher. For protection of participants, data used in this final report has been de-identified, with pseudonyms or general descriptions used to refer to a worker or homeless adult's comments.

Data Analysis

Data was analyzed using a thematic analysis approach in which patterns within the data were identified, analyzed, and reported on. Analysis started with repeated, active readings of the transcripts to gain familiarity with the data and to search for meanings, patterns, and differences (Braun & Clark, 2006). Raw data from transcripts were condensed into initial codes utilizing the list of ideas generated during the repeated reading process and analyzing each sentence of the transcript to distill the meaning of the sentence into a word or two. Some theory-driven codes, such as safety and shelter capacity, were actively searched for. Data that fell outside the norm or seemed unusual in comparison to most of the data was focused on to illustrate differences.

Codes were sorted into broader themes. This process involved searching for similarities and differences in the codes, identifying linkages between codes, and identifying how they fit together into themes and sub-themes. Themes were reviewed and refined by verifying that themes resulted from coherent patterns in the data and that themes were valid in relation to the data set (Braun & Clark, 2006). The data was re-read to determine whether the themes worked, were consistent, and did not overlap. During the re-read, data that may have been missed in earlier coding stages was re-coded into the existing themes.

Respondent's direct quotes are used to illustrate themes.

Findings

The focus of this research was to examine barriers perceived by workers and homeless adults that impact utilization of emergency shelters. A study of this nature would not be complete without first examining whether and why homeless adults utilize shelters, shelter capacity, shelter alternatives, risks homeless adults encounter when they do not utilize shelters, and additional services homeless adults use. Each of these themes is discussed in detail below, with respondent and worker's quotes used to illustrate themes.

Safety was a far more complex issue than was first thought and was found to be one of many decisional factors homeless adults weighed in deciding whether to use shelters and which shelters to use. Additional decisional factors played a role in homeless adult's decision to use shelters, including shelter location and environment, shelter rules, and autonomy and dignity. The working theory for this study was that unsheltered homeless adults do not use homeless shelters due to fears for their safety and that there are an inadequate number of shelter beds available to accommodate the homeless population, resulting in some being turned away from shelters. Support for this theory was not found, and a new theory was developed. The revised theory is that homeless adults make the decision on whether to use shelters by considering and weighing the risks and rewards of a variety of factors, and there is usually a tradeoff that requires the homeless adult to sacrifice or lose something in order to gain shelter.

Shelter Usage: Necessity Not Choice

All of the homeless adult respondents had used shelters the evening prior to their interview, and reported using shelters regularly. Some respondents had one shelter they preferred and used with some regularity, while others described having used a few preferred shelters. Respondents generally disliked shelters. Statements such as, "I don't like staying...

don't like the shelter," and "I don't like being there, but I deal with it," were common. Respondents were clear that they utilized shelters only out of necessity and, given the presence of any other choice, they would prefer not to have to use shelters.

Most respondents stated they would use shelters again, but again clarified this was out of necessity. Respondents indicated they used shelters more in the wintertime than in the warmer months, because the shelter allowed them protection from extreme cold: "There's no benefits to being in a shelter. Nobody wants to be in a shelter. It's just a place to lay down and stay warm." In addition, many respondents utilized shelters to escape the stresses and dangers of the streets: "Outside's dangerous. It's worse than a shelter. Anything can happen out there." Workers reported these sentiments were common of long-term homeless adults they had worked with.

Shelter Capacity

One theory underlying this study was that unsheltered homeless adults do not use homeless shelters because there are an inadequate number of shelter beds available to accommodate the homeless population, resulting in some being turned away from shelters. This theory was based on common knowledge among social services professionals in the Twin Cities area that there are not enough shelter beds to accommodate the number of homeless individuals in the area. However, no support for this theory was found in the data. Though respondents reported arriving late at shelter might require sleeping on a mat on the floor versus in a bunk, none reported being barred from shelters because of a lack of beds or space. Some respondents reported they could always try larger shelters if they found the smaller shelters were full.

Shelter Alternatives

Both respondents and workers described a variety of alternatives to shelter that are utilized by homeless adults in lieu of shelters. Workers reported staying outside, sleeping in cars and abandoned buildings, riding the bus all night, going to 24 hour restaurants and retail facilities, and staying with family, friends, or acquaintances (often referred to as couch-hopping) as alternatives to shelter utilized by homeless adults. One worker reported clients forced to utilize unsuitable alternatives would often sleep during the day: “Some are hanging out at Wal-Mart or Denny’s all night and then they come to our drop in center and they sleep for a couple of hours during the day.”

Respondents described several alternatives, in addition to the ones already mentioned by workers, that they used when they preferred not to stay in shelters. Shelter alternatives identified by homeless adult respondents included parks and park benches, abandoned houses and buildings, and bus stops. All respondents shared experiences of couch-hopping. One respondent reported occasionally feigning an injury in order to utilize the hospital for a safe place to stay. A few respondents reported getting let into apartment buildings and finding places such as laundry rooms, hallways, attic access points, and storage spaces to stay inside. Ernest shared one such experience:

And, one night it was just so cold and I was like: well, I’m not going outside. But it was warmer in the hallway than being outside, so I slept in there about a couple of times...It’s a stairwell like above a stairs. The door opens, like you can keep storage in there or something. You can put a lock on it. There was stuff in there, but there was enough space where you could lay down in there. Somewhere where you wouldn’t want to sleep. Put it that way.

One worker reported these types of solution were not uncommon and that commercial buildings were likely to be used as well. Many respondents exhibited resourcefulness and ingenuity in coming up with outside alternatives to shelter. Angela, for example, described using two unused plastic garbage cans to create an enclosed tube in which to spend the night.

Desperation to have a safe place to stay compelled some respondents to consider restrictive alternatives, such as jail or chemical dependency treatment facilities. Having been homeless continuously for a number of years, Marvin was desperate for a safe place to stay and was even willing to do jail time for a crime he did not commit in order to secure a safe place to stay: “I said, ‘Oh good, how long I be locked up for? Like a month?’ ...They was lookin’ at me like I was crazy and they put me out. They wouldn’t even lock me up.” Two respondents considered entering chemical dependency treatment, even though neither felt they needed it, in order to have a longer-term place to stay.

Risks Of Not Utilizing Shelter

Respondents and workers identified victimization, crime, and health as risks homeless adults encountered when not using shelters.

Victimization. Couch-hopping alternatives are often risky. Many respondents reported being taken advantage of by hosts who expected some form of compensation. One respondent said, “Most people feel like they want something from you. You’re staying with me, so what you going to do for me? What are you going to buy me?” Workers reported such problems in couch-hopping arrangements likely occur because, out of desperation, homeless adults stay with people they hardly know who they might not stay with otherwise.

Respondent, Angela, illustrated the danger of couch-hopping arrangements born of meeting people on the streets:

[I was] sexually taken advantage of. I pay people to stay at their place. I pay like \$30.00 a night, and then they wake me up at 3:15 pawing on me and everything...it's a thundershower going on and they're talking about, "I want some sex," and I'm like, "I paid you money; I'm not going to have sex..." Then, they tell me to get up and get out, and I had to. So that's happened to me on two occasions with two different people. I knew them since I've been homeless.

Male respondents were more likely to report being victims of theft when staying with people they did not know well. Some male respondents had lost money and belongings to theft numerous times as a result of staying with people they had only recently met or knew from the streets.

Respondents also reported being victimized by strangers while on the streets. Many respondents described incidents in which they were robbed, and some of these encounters resulted in injuries. Angela described multiple experiences of being robbed, and described these incidents as being not only traumatic, but also resulting in injuries that required medical attention. She said, "It was so traumatizing I had to call the Crisis Connection...I was just a bundle of raw nerves. I couldn't believe it. I said, 'Oh my God; I can't keep doing this.'"

Crime. Workers reported many homeless individuals build up criminal records, some of which are often long, that include a lot of minor charges for what workers referred to as homeless crimes such as loitering, public urination, and drinking in public. Homeless respondents reported having been charged with theft and trespassing, and asserted these were crimes committed in order to survive. One respondent reported being arrested for loitering when caught sleeping outside or in other places unfit for human habitation. A third respondent's lack of transportation compelled him to risk riding the Light Rail without

having paid for a ticket: “I’ll try to hop a train. If I see that cop, I’ll get off...If you see a guy in blue, get the hell off the train real quick—next stop—and walk. It’s a \$185.00 fine if you get caught.” Some respondents reported incurring criminal charges for reasons not related to survival. Two respondents discussed drug related crimes, and one respondent was criminally charged with check forgery and sentenced to probation as a result of being taken advantage of by a stranger who had him rake leaves and work on a porch on a house and then paid him with a forged check.

Health. Workers reported health issues were a risk of homeless adults who do not utilize shelters. Workers identified frostbite and hypothermia as dangerous health risks homeless adults exposed to the elements encountered. Workers indicated it was common for homeless adults to have a variety of health related issues, as well as chemical and mental health issues. Two homeless adult respondents commented on the increased likelihood of homeless individuals, including themselves, to abuse substances: “A lot of times when you’re homeless I tend to use, a lot of people just tend to give the fuck up and start using.” Another respondent revealed that he recently found out that he was HIV positive, and though he admitted he likely contracted the disease from unprotected sex, he stated, “I blame that from the streets.” Being homeless impacted his ability to receive proper care, which he felt was partially his fault for missing appointments and not taking his medications as prescribed, but was also a result of issues in a medical system that insisted he see nurses and nurse practitioners rather than a doctor.

Service Utilization

Respondents described benefiting from shelter services and a variety of additional services they used in addition to shelters, including drop-in centers, daytime resource centers,

clothing closets, food shelves, case management, Adult Rehabilitative Mental Health Services (ARMHS), outreach workers, and housing programs and resources. Respondents identified a lack of weekend services as a gap.

Service benefits. Some respondents reported receiving only minimal benefits from using shelter, which they described as providing only basic needs services such as meals, showers, and bathrooms. In addition to basic needs services, some respondents identified workout equipment, on-site doctors, laundry facilities, and groups and classes offered at some shelters as benefits. Some respondents reported there was additional help available at shelters, such as housing services, but that shelter users needed to be proactive to access such services. One respondent stated, “There’s help there if you want it. Like I just said, if you ain’t trying to help yourself, ain’t nobody going to help you if you’re not going to help yourself.” Respondents appreciated that some shelters offered savings programs that would help shelter users save money to use towards housing and offered the additional benefit of being able to stay at the shelter longer. Respondents generally held positive views of the services they utilized, and made it clear they utilized services only to meet their direct needs and not simply because services were available. For example, one respondent utilized food shelves, but was careful to only take the food he could use. He restricted himself to only pre-packaged items or items he could microwave at work, as he did not have access to cooking facilities.

Workers confirmed that housing and other supports, including access to mental health case management, CADI waiver assessments, and access to other social services, were available at some shelters. One worker felt the availability of such services might make utilizing shelter worthwhile, as the connection to permanent housing services that could help

users out of shelters might offer “enough hope to deal with the parts of shelter that are not as pleasant.” Another worker’s experience was not as encouraging, but may reinforce homeless adult respondents’ experiences that users wanting housing and other services at shelter need to play a more proactive role or may indicate that there may not be enough advocates to work with every user who wants help. This worker reported she would refer clients to shelter for assistance from outreach workers, but they would often return to her telling her nobody was helping them.

Respondents reported they were more likely to revisit shelters if they had a previous positive experience. Support and positive relations with staff and other shelter users were identified as a large factor in whether a user’s experience was positive. Respondents described positive interactions with staff as those in which they felt cared about and supported and were treated like human beings. Workers felt support some shelter users received from peers who had similar experiences and struggles was an important benefit of some women’s shelters, as even momentary support seemed to instill hope and encourage shelter users to access needed services and resources. Workers also described staff at some shelters as being more supportive. One worker reported that, for some women, this support was so profound that they experienced difficulty leaving the shelter even though housing had been secured. She stated, “I even had people there [Small Shelter] that we offered housing to that we had to talk into leaving there...they didn’t want to leave there. They really got comfortable there.”

In addition to shelters, participants described using a variety of other services such as drop-in centers, daytime resource centers, clothing closets, food shelves, and housing programs and resources. Daytime services were popular, as they offered a safe place for

homeless adults to spend daytime hours. Drop-in and resource centers offered benefits including mail services; computers on which users could apply for jobs, look for housing, or check email; daytime meals; and support and activity groups. Without these services, and without access to transportation, respondents reported having nowhere else to go or spending their days walking to a variety of locations such as libraries, retail stores, and through skyways in order to stay warm during the cold winter daytime hours. Ernest illustrates the daily struggle faced by homeless adults who must find ways to fill their daytime hours:

That's the worst thing is dealing with that in the daytime when you don't have any job or nothing...it's worse if you're not doing something, because you're not doing anything. I just hate it...It's hard to go places when you have no transportation and no money...That's what makes you tired is walking—downtown, you walk here [Drop-in Center], you walk across the bridge, and you walk to Minnehaha Falls, walk to St. Paul or whatever. You think of places to walk.

Respondents built daytime routines wherein they utilized a variety of daily resource centers and drop-in centers. Respondents described schedules in which they would leave the shelter in the morning, visit a resource center for breakfast, head over to a drop-in center for groups and activities in the afternoon hours, and walk or catch a bus back to shelter to arrive on time to secure a bed.

Catholic Charities' Opportunity Center, a daytime resource center also referred to as The Branch by some respondents, was most often mentioned and utilized by respondents. The center hours, 7 a.m. to 4:30 p.m. in the winter and 7 a.m. to 3 p.m. in the summer, and the provision of breakfast made it a good daytime option for those leaving shelters between 6 a.m. and 8 a.m. The Opportunity Center offers basic needs services including meals,

showers, lockers, laundry, and informational resources, and bills itself as a “one-stop-shop,” to move homeless and near-homeless populations towards increased stability (Catholic Charities, 2015). In addition to the basic needs services previously mentioned, The Opportunity Center offers counseling services; culinary skills training; employment assistance; foot care and haircuts; on-site health care; screening for services including shelter, county benefits, mental health services, medical, and other programs; voicemail and mail; ID and birth certificate assistance; SNAP and MNSure enrollment assistance; and Rapid Re-housing (Catholic Charities, 2015). Respondents described benefiting from a variety of the services offered at The Opportunity Center including medical, outreach, meals, ID and birth certificate assistance, and accessing other social services, and also building relationships with the staff. One respondent said, “I go to the doctor there sometimes for like cough drops. They give you cough drops and different things. I talk to some of the staff. I’m really close with a lot of the staff.”

Service gaps. Lack of daytime services on the weekends was a complaint shared by many respondents, with Sundays being particularly difficult. Respondents reported many services were not open or available on Sundays, compelling them to find other places to go for shelter during daytime hours such as churches, retail establishments, and restaurants. The drop-in center at which interviews were conducted is open on some Saturdays, which respondents indicated was a definite advantage. One respondent stated, “And then on Saturdays, I’m so glad that y’all will be opening on Saturdays...like every other Saturday, I do that. I come here.” Respondents reported some shelters open early on weekends, which they appreciated, but still left them with many daytime hours to find a way to fill.

Decisional Factors

Respondents described a variety of decisional factors they weighed when deciding whether to stay at a shelter and which shelter to use. These factors included safety, shelter location and environment, shelter rules, and autonomy and dignity. Each is described in further detail below.

Safety. One theory underlying this study was that homeless adults do not use shelters, because they fear them to be unsafe. No support for this theory was found. Though respondents and workers identified safety issues at shelters, they could not accurately be called a barrier, because they did not prevent homeless adults from using shelters. The streets were found to be significantly more risky and dangerous than shelters, and the way homeless adults considered safety was more complex than whether shelters were safer than the streets, as additional decisional factors discussed later on were also weighed as part of the decision making process. In light of these findings, a revised theory was formed. The revised theory is that homeless adults make the decision on whether to use shelters by considering and weighing the risks and rewards of a variety of factors, and there is usually a tradeoff that requires the homeless adult to sacrifice or lose something in order to gain shelter. Safety is one factor homeless adults consider while making the decision on whether to use a shelter and which shelter to use.

Street safety. Respondents described being on the streets and utilizing other shelter alternatives as dangerous. One respondent said, “You can’t be on the streets, because you can get in trouble on the streets. You don’t need to be out there.” Another said, “It can be tough out there. Ya know, I’ve seen people die on the streets out here.” Workers described assault, theft, and health risks as dangers encountered by homeless adults on the streets. Workers reported the areas surrounding large shelters, in particular, felt unsafe due to the amount of

people “milling around” and the presence of gang activity. Workers identified police harassment as another risk of sleeping on the streets and utilizing other alternatives for shelter. One worker shared a story of a client who was trying to warm up at a transit station who was harassed by a police officer who saw an empty liquor bottle near the individual and assumed it was his. The worker said, “I hear these kinds of stories all the time, so I tend to think there is truth to them.”

Homeless adults confirmed police encounters were a real risk. All respondents described at least one incident in which the police found them sleeping outdoors or in another location not meant for habitation and told them they could not stay there. One respondent stated, “The police done came in and woke me up many times. That’s why I’ve got a lot of trespasses.” Respondents reported police harassment was an issue during daytime hours as well. One respondent stated, “Yeah, they harass me. ‘What is you doing out here?’ And then I tell ‘em, ‘Just cause I’m homeless why do y’all want to stop at the bus stop when I’m getting ready to catch the bus?’”

Some respondents reported that violence on the streets was a danger, and that simply being in the wrong place at the wrong time opened one up to becoming a victim of violence. Angela sustained a serious leg injury that developed cellulitis after she tripped while running to escape gun violence that had broken out on the street she was walking down. Angela also shared a story in which she narrowly avoided losing her life:

I almost got in the car with the Theodore Wirth murderer. I thought he was a friend of mine...I ran to get ready to ask him for a ride, and I opened the door and the guy looked like he was as black as that filing cabinet, but his eyes were beet red, and it was God showing me, I know it was God showing me that he was not to be trusted...I

said, “Oh I thought you were somebody I knew. I’m sorry,” and I slammed the door...I peed on myself. I had no control and I was shaking...One night I turned on the news, and they said we’ve captured the Theodore Wirth murderer; he killed seven women and one transvestite in Theodore Wirth Park by pouring gasoline on them and setting them on fire...I couldn’t believe it.

Respondents also described encounters with gang violence that often erupted into gunfire as a danger of the streets. Marvin, a former gang member, was seriously injured when “gang bangers” mistook him for someone else and confronted him at a bus stop. Marvin reported he was hit in the face with a big gun as he tried to protect a woman and her children after the woman had stood up for him; both he and the woman were shot. Marvin has a bullet that remains in his foot and a large facial scar as a result of this incident.

Fear of sleeping outside impacted both the quality and quantity of homeless adults’ sleep. One respondent stated, “When I’m outside, I really don’t sleep. I close my eyes, but I can hear people. I’m going to stay vigilant no matter what, because you don’t know what’s going to hurt you out there.” Another said, “Yeah, I was scared. You can’t sleep when you’re scared.” Respondents reported indoor alternatives that were not meant for habitation were also not conducive to sleep due to fears of being caught. Only one respondent reported his fears did not deter him from sleeping outside or in places not meant for habitation, and asserted he preferred the streets to shelters.

Shelter safety. Most respondents felt shelters were generally safe, and all but one felt shelters were safer than the streets: “Well, a shelter is better than being out on the street. It’s safer in a shelter,” and “I feel safer in a shelter as opposed to being outside, because you’re out there with the elements.” Respondents reported they slept better at shelter than on the

street, because shelters were warmer and safer. Respondents felt safety measures, including security cameras and on-site police or security, assured increased safety. Some shelters were viewed as being safer than others, and this seemed to be based on the location and the size of the shelters, with larger shelters viewed as less safe.

Respondents identified drugs, alcohol, theft, and violence as safety issues prevalent at shelters, with theft and violence being mentioned most often as safety issues experienced by respondents. Respondents described witnessing violent incidents including fights, and expressed fears of being shot or stabbed. While most respondents had personal stories of either having witnessed violence or theft, or having personally been victims of these crimes while at shelter, they still felt shelters were safer than the streets and other alternatives. Workers corroborated respondents' safety concerns, citing theft and violence as safety issues. Workers described medications being lost or stolen at shelters as an issue faced by homeless adults. Workers also felt stereotypes of shelters as unsafe places and bad experiences impacted homeless adults' perceptions of shelter, and that often one negative experience weighed heavily enough in the individual's mind that they would not return to shelter.

Workers and respondents described increased police presence used as a safety measure at some larger shelters to mitigate problems in areas surrounding shelters. However, according to one worker, increased police presence and the addition of cameras did not necessarily increase feelings of safety. Instead, these measures drew attention to the possibility of safety issues, creating a "heightened sense of awareness of being unsafe." In addition, increased police presence was experienced as threatening by some homeless adults who do not trust the police. Workers identified the presences of drugs and alcohol at some shelters as an issue for clients recovering from substance use disorders. Another worker

noted that shelters could be particularly uncomfortable and unsafe for transgender adults, who, in order to comply with county policies of segregating genders at shelters, must stay with the gender their state issued ID identifies them as, rather than the gender they personally identify as. She described such policies as strict, stating, "...so even this person that was transitioning and had all the legal documents moving along in the process could not move to the third floor until she had her ID that said female on it."

Shelter location and environment. Homeless adult respondents revealed a clear preference for smaller capacity shelters located further away from urban downtown areas. Smaller shelters were described as being better because they were cleaner, less crowded, and had staff that was more supportive and caring. Workers' experiences confirmed a preference for smaller shelters. One worker described going to smaller shelters as feeling "like a breath of fresh air" after spending most of her time in a large downtown shelter; she stated, "I think some of the shelters have a worse reputation in town too...What I hear from clients is that [Large Downtown Shelter] is kind of the worst in the city." Workers reported shelter users generally seemed more comfortable and seemed to get along better at smaller shelters.

Many respondents described larger shelters located in downtown areas as being the worst, because they were dirtier and more crowded. One respondent stated, "[Large Shelter] needs to be shut down," another called the same large shelter "inhumane," and one respondent used the word "disgusting" to describe the shelter environment. Some respondents proclaimed they would only stay in such shelters as a last resort, and others asserted they would not even use the large shelter as a last resort. One respondent stated, "No. Heck no. [Large Shelter]? Never...No. Nope."

Shelters that offered long-term beds for a fee were preferred for the stability they offered and because there was greater freedom to come and go. However, these arrangements were not easy to secure: “I been going consistently every Monday, and I never got a 28-day bed until just this Monday for the first time in five months.” Long-term arrangements also did not extend beyond the 28-day period; one respondent who currently had a long-term bed reported he would have to reapply and endure another wait of at least a month in order to try to obtain another 28-day bed. Further, workers felt fees for such arrangements served as a barrier for some users. A homeless adult respondent who currently had a 28-day bed commented on the prohibitive cost, stating: “...my bed runs out on Monday, so I’ll either go back to the lottery or join the savings, but I’m not working a steady ticket now, so I don’t know if I’ll be able to do that.” Some shelters also have respite programs designed to provide care for individuals being discharged from hospitals for serious medical issues such as heart attacks or broken limbs. Workers reported these programs were also cost prohibitive for some users, and that some homeless individuals would refuse placement in these programs because of the cost. A homeless adult respondent agreed with this assessment: “I had a chance to stay in respite, but I would have had to pay them all my money but \$95.00, so I said no.”

Shelter rules. Respondents generally seemed to accept that utilizing shelter meant abiding by certain rules. “Rules are rules,” and “You just need to know the rules before you go in there...If you don’t agree, move on. Somebody else who does will be right there,” were comments shared by respondents. All shelters had curfew rules that dictated the time one must arrive to secure shelter for the evening and the time shelter guests must leave in the morning. Generally, arrival times were between 4 p.m. and 5 p.m. and departure times were

between 6 a.m. and 8 a.m., with some shelters extending morning hours on particularly cold days. Respondents disliked curfew rules and communicated it was more difficult to accept such rules when it was cold outside, as they were often forced to stand in long lines in the cold while waiting to enter the shelter and were left on the streets in the cold for an hour or more in the morning during the gap between having to leave shelter and waiting for other services to open. Respondents expressed appreciation for cold weather exceptions to these rules, which allowed some shelters to extend morning hours when outside temperatures were below zero and other shelters to stay open all day some days.

Workers felt curfew rules were barriers for some users: “I would say the lottery system can be a barrier because they have to be there at a specific time,” and “Also, I think there’s that limit too of they have to get up early and be out by a certain time. And then where are they going to go at that time of the morning?” Some workers reported such rules created difficulty for shelter users who work, because curfews may not align with part time job schedules, and those who work nightshifts were left without options for shelter.

Respondents identified shelter rules designed to increase safety. Respondents described rules dictating bag searches to enter shelters and rules prohibiting fighting, which if broken, would cause an individual to lose their bed for the night and to be banned from the shelter for six months. Respondents described rules prohibiting fighting as harsh, because victims of assault who were fighting back to protect themselves were treated as though they broke the rules regarding fighting. One respondent felt safety rules just created the illusion of safety, stating, “They kind of search you when you come in, but they can’t fully search you. Sometimes they’ll see a bunch of clothes on top and not even bother to do the rest.”

Workers thought county rules requiring users to voucher in to some shelters discouraged some homeless adults from using shelters: “Yeah, I think navigating the whole county rules of the shelter can be a deterrent for folks.” Workers also thought lack of clarity around shelter rules and inconsistent enforcement impacted shelter users, who feared losing their bed if they did not abide by rules, even though compliance of rules was made difficult when users did not really know what the rules were. One worker said, “...there’s always that kind of underlying fear...and the rules are always changing; those types [rules regarding using appropriate language] are always changing...It’s really stressful in that regard. It’s just a really hard place to be.”

Workers indicated some shelters have rules requiring users to be sober, which presents a problem for individuals with substance use disorders. One worker reported some shelter users might want to use before going to shelter as a form of self-medication for their anxiety, which would often become worse in the crowded, noisy shelter environment. One worker felt sobriety policies were beneficial: “I also have seen people that was a benefit for. They had been sober, and you have to be sober, and they didn’t want to be around people that were under the influence.” Homeless adults respondents reported that some shelters that have sobriety rules do not always enforce them. Some respondents asserted shelter users under the influence of substances created problems for other users, because they would start arguments that could escalate to physical violence.

Some smaller shelters located in mixed use or primarily residential areas have Good Neighbor Agreements designed to enable the shelter, neighborhood residents, and businesses to address issues of concern and to mitigate disorderly behavior or actions that may be disruptive to residents or businesses. Agreements typically outline services provided by the

shelter as well as responsibilities of all parties to maintain the harmony of the neighborhood. One respondent reported Good Neighbor policies as having an impact on users of smaller shelters located in residential areas, especially on cold days, because sitting at nearby bus stops to remain warm while waiting to enter shelter was a violation of these policies that could result in some users being restricted from both the shelter and the resource center run by the same agency.

Autonomy and dignity. Homeless adult respondents expressed a need for independence and autonomy. Angela, who was homeless in part because she was fleeing domestic violence, was clear about her need for autonomy, stating, “After my husband, I swear to goodness I’m going to be independent...This is the first chance I’ve ever gotten to run my life since I was born...and nobody is going to take that from me.” Marvin offered a compelling example of the importance placed on preserving autonomy and dignity. Marvin hid his homelessness from his family for a number of years in order to preserve his dignity and to prevent his mother and sister, who live in different states, from pressuring or forcing him to move in with them:

And I was like, “No, mom, I want to stay here. I want to get a place and then I want y’all to come to my place.” I’ve been telling them that for 14 years. My little nieces and nephews are like, “Uncle [Marvin] the last time we came to Minnesota we had to go to a hotel,” because I had to take them to a hotel by the Mall of America...They never thought about Uncle [Marvin] where do you live until last year. They started saying, “Where do you live? What’s your address?”...I’m like I stay over north and try to spin it and tell them something. When they got here to visit the U of M I did the same thing. I met them...[They asked] “Are we going to your house?” I’m like, “No,

we're going to the hotel." They're like, "Uncle [Marvin], why do we always go to the hotel every time we come to Minnesota?" I was like, "Cause I don't like my neighborhood." They know [I'm homeless] now. All of 'em.

Workers felt shelter rules restricted autonomy by requiring adults to live under "somebody else's rule." In addition, the structure created by such rules was perceived by workers to be particularly difficult for long-term homeless adults, many of whom had spent a long time on the streets and lived typically unstructured lives. However, one homeless respondent who worked stated he saw the structure as a benefit, because it provided stability: "I've lost jobs because of not coming to work on time, or being late or whatever, and I contribute that to being homeless... You need somewhere where you can bathe, wash up, change clothes... where you can sleep and rest." Another homeless adult respondent felt the structure created by shelter rules created an institutional feel: "I just feel like its prison for me now. Institutionalized. I'm so used to it now. It's all I even know. Get off work, go to the shelter..."

One worker felt shelter rules violated dignity of users: "I feel like it's like shaming, even though it's not what's intended. I would imagine they [shelter users] feel pretty bad that they're still in that position, and it's degrading." One homeless adult respondent took issue with the fact that only shelter users are subjected to safety rules, particularly those pertaining to bag checks, while shelter workers were not expected to abide by such rules. This violated shelter users' dignity, because it implied shelter workers were somehow better than shelter users. Respondents also felt shelter workers treated users unfairly, showing favoritism to some shelter users: "I don't have a problem with them, but they've got their favorites though... You can tell. Yeah, you can tell." This favoritism often resulted in unequal

enforcement of rules. A worker confirmed that some shelter workers may show favoritism, and would bend the rules for some guests: "...and they're [the rules] different for each person sometimes, depending on whether the advocate likes the client or not."

In addition to favoritism, respondents felt some shelter workers mistreated shelter users in other ways that violated their dignity: "[Workers] treat you like a child... 'You need to do this. And you've gotta get up,'" and "They degrade you. They tell you to shut up. They tell you you're no good. They call you a 'B'," were comments shared by respondents. Workers also used words, such as "degrading" and "demeaning" to describe the ways in which some shelter workers treated guests. Workers felt mistreatment by workers created additional stress for shelter guests who had to remain vigilant of mistreatment by staff. Respondents felt they had no recourse against mistreatment by shelter workers, and most feared some sort of retaliation if they reported a worker for mistreatment: "Well, if you try to report them, and they find out, then they hold that against you." One respondent excused some shelter workers' mistreatment of guests as a result of the difficult work they are required to do and another felt it was incumbent upon shelter guests to earn the respect of the workers: "Most of them are fairly nice and they genuinely want to help you... If you won't put your best foot forward, they're not going to help you. You can't expect that."

Again, differences between larger and smaller shelters were observed. Workers and homeless respondents agreed that workers at smaller shelters treated shelter users better. One worker stated, "My experience at [Small Shelter] is the shelter workers that work there are great advocates for the client, and really help them get their needs met and they're very respectful to shelter guests." Respondents also indicated staff at smaller shelters were better, and described them in positive terms like "wonderful." In contrast, one respondent held a

negative view of workers at a larger shelter: “At [Large Shelter] you’re a peon. You’re nothing...”

Mistreatment of homeless persons was not limited to shelter workers, but occurred with other service providers as well. A worker reported she had clients who had unpleasant experiences with county shelter teams with whom they had to work to access shelter, because these workers seemed judgmental of individuals who already felt as though they had to prove their worthiness for shelter. Many respondents shared experiences of mistreatment by various providers. Respondents felt the police lacked compassion for the plight of the homeless, as they would often make homeless adults discovered sleeping on the streets get up and move. Homeless adults also reported being mistreated by medical professionals. Marvin described such mistreatment:

If you homeless you oughta see it if you go to the doctor. If you go to a doctor right now and you homeless, you oughta see how fast they’ll try to get you out of there. Seriously... They said your address is [Large Shelter Address]. They said, “Large Shelter?” And I said, “Yes.” Man, you oughta see how fast they get rid of me.

Angela stated “impersonal” and negative treatment by medical staff at a hospital resulted in her not receiving medical treatment she needed: “...my heart was sick, so I went and laid down at my son’s house.” Another respondent identified a misguided attempt by service providers trying to illustrate their understanding of homelessness through the presentation of a play as both unhelpful and offensive.

Another worker commented that stigma perpetuated by workers was an issue, stating, “I don’t know why, but we all tend to lump people who are experiencing homelessness all in the same category of folks who are experiencing homelessness, even though they are all

individuals experiencing homelessness.” Homeless adults also felt stigmatized as a result of being homeless. One respondent stated, “But, some people that say they will help you out here actually look down on you when you’re homeless. Because they’re terrified. I’m like homeless people are the same as you; we just don’t have a home.” Another respondent said, “...everybody that’s homeless is out to beat people. That’s what they think. Everybody that’s homeless, they think that you out for something. You tryin’ to do something to harm them or you tryin’ to take something from them.” Marvin asserted he was often stigmatized by police officers who seemed to automatically assume he was “up to no good,” because he was African American and had a large scar on his face.

Alternatively, some respondents reported experiences of feeling cared for by workers or others, which had a positive impact. Respondents described feeling cared for when workers treated them like human beings, listened to them, showed understanding of their struggles, and offered support and comfort. Respondents caught sleeping in apartment buildings by residents were surprised when some residents seemed to understand and feel sympathy for their plight and even offered to check in on them.

Barriers to Exiting Homelessness

In contrast to earlier findings in which factors typically considered to be barriers to using shelter were actually not true barriers, but rather factors homeless adults weigh in their decision on whether to use shelters, true barriers to exiting homelessness were identified by workers and homeless participants. Affordable housing, market rate rental requirements, legislative and housing program policies, and other factors were identified as true barriers that prevent homeless adults from securing and maintaining stable housing. These barriers are discussed in detail below.

Workers and homeless participants both identified lack of affordable housing as a barrier that prevented homeless adults from exiting homelessness. Some respondents indicated their income restricted their ability to pay market rates rents, making affordable housing a necessity: “I’ve been working like \$7.00-\$8.00 jobs in shops, labor jobs, working at temp places. Jobs where it’s hard work, but you really don’t get any pay.” One respondent stated he wanted to work, but encountered difficulty finding and keeping a job that offered consistent hours. Workers reported lack of affordable housing was an issue throughout the state, limiting the amount of housing help workers were able to provide. “A lot of the lists aren’t even open,” and “Housing is an issue everywhere...I know that housing just isn’t available for every single person who steps in shelter. It can’t be,” were comments shared by workers.

Respondents expressed frustration with long waiting lists for affordable housing. One respondent stated homelessness contributed to his inability to maintain his spot on housing lists: “You just never know what’s going to happen if you’re homeless everyday. You’re on a list. I didn’t think I was going to go to jail today...You come out and you’ve got to start all over again.” Workers corroborated that there are long waits for affordable housing: “I have some housing clients I’ve worked with for well over a year and are still on my search list, and I would tell some of them it’s going to be a long process.” Workers attributed long waits to the large caseloads of housing workers, created by a high demand for affordable housing that is not available.

Workers reported that shelters served as an access point for housing. One worker reported some housing programs took shelter users first. Workers asserted shelter workers had more access to some housing opportunities, such as some transitional housing that is

only accessible through shelter workers, and that staying at shelter proved homelessness, which increased shelter users' eligibility for housing programs. One worker said:

It didn't take me long to realize that there's a lot of vouchers out there for the homeless, but you must be HUD homeless. One very good reason to go to a shelter is you're registered. You are now officially homeless, whereas if you are couch-hopping, you're not and you'll never access those vouchers...That's a very good reason to go [to shelter] is you open more doors.

Workers also identified legislative policies surrounding funding for certain housing programs as barriers. One worker reported Group Residential Housing (GRH) funding policies required that individuals stay at shelter the night before entering the program, and that client's coming out of a large shelter were given preference by some GRH housing providers because service rates were higher for these individuals than those who did not spend the night at the large shelter. She stated, "There's some silly legislation that was created somewhere that nobody even realized the impact of it until it was into practice. You know it's a dumb policy when even the shelter team is saying, 'This is dumb.'" Another worker shared that this policy impacted a housing program at which she had worked, forcing them to convert some existing apartments that had previously been paid for with vouchers to GRH, which resulted in existing residents being forced to leave their apartments to stay at a shelter overnight in order to meet new eligibility requirements.

Workers felt that the HUD homeless criteria followed by many housing programs, and particularly criteria surround proving homelessness, barred some homeless adults from accessing housing programs. Workers thought policies requiring individuals to stay at shelters to prove homelessness created a barrier for individuals who were most in need of

housing: those who often stayed in places not meant for habitation instead of shelters. One worker said, “I think that it is rather unfair that you have to be using the shelter or somehow get documented as living in a place not meant for habitation, because those clients who won’t are just locked out...” Workers also advocated for more access points to transitional housing and voucher programs, and thought this should take the form of more ways to prove homelessness.

Workers reported that many drop-in centers have workers that can assist homeless adults with finding housing; however, their access is often limited to openings that charge market rate rent, which is unaffordable for most homeless individuals. Requirements of market rate properties, including that renters have a monthly income that is at least two and a half times the amount of rent and that renters pay first and last months’ rent up front, rendered such properties inaccessible to homeless adults with limited income. A homeless adult respondent had encountered this barrier: “...they want the first and last months’ [rent], and it’s double and I can’t afford that.” One worker stated some individuals moved into market rate apartments out of desperation, even if the price of rent was nearly the full amount of their income, which created additional problems: “One extra expense and they won’t be able to meet their rent, and then they’ve got an eviction and the problem is bigger then because it’s much harder [to secure housing] with the evictions.”

Both workers and respondents identified additional barriers to homeless adults securing and maintaining stable, permanent housing. One worker indicated that some affordable housing options were nicer than others, which resulted in some clients in a housing program staying on vouchers and with the program longer than they should, because they viewed moving to Section 8 properties as a step back. One respondent identified

unethical landlords, which he termed “slumlords,” as a problem to maintaining housing. Another respondent identified poor follow through by workers as a barrier to obtaining housing: “...he [housing worker] was like, ‘Let me check my email,’ and she had emailed him about two weeks ago...I got kind of upset.” A third respondent identified a combination of factors including workers not understanding his needs, feeling forced into accepting housing he did not want, and poor communication between himself and the worker that served as barrier to obtaining housing, and reported he lost a housing voucher when he was unable to make an appointment to sign paperwork on an apartment because he did not have transportation. Ernest, who had been homeless continuously for eight years, identified fear and need for additional services as potential barriers to maintaining housing:

Yeah, and in a way scared. I’ve been homeless for so long...I’m not saying I’m getting used to it, but I know what to expect. If I did have a crib, it would probably take a little time for me to get adjusted to having a crib, and I would probably need somebody like a payee or somebody to help me pay my rent...I know me. I’ll end up spending some money doing something stupid that I know I’m going to regret.

Discussion

The focus of this study was to examine barriers perceived by workers and homeless adults that impact utilization of emergency shelters. Themes on whether and why homeless adults utilize shelters, shelter capacity, alternatives to shelter, risks homeless adults encounter when they do not utilize shelters, and additional services homeless adults use were presented as a knowledge base that establishes the importance of shelters to homeless adults. Safety and other decisional factors, including shelter location and environment, shelter rules, and

autonomy and dignity, were found to play a role in a homeless adult's decision to use shelters. Finally, barriers to exiting homelessness were presented and discussed.

Health, crime, and victimization were mentioned in the literature as risks encountered by unsheltered homeless adults in their day-to-day lives. The findings of this study corroborate the literature, as crime, victimization, and health were all found to be risks encountered by homeless adults who do not utilize shelters. According to the literature, policies restricting the length of stay at shelters, particularly those limiting shelter use to evening and overnights, eliminate shelter as an option for some homeless individuals, as these policies left homeless individuals without daytime shelter (Gilderbloom et al., 2010; NCH, 2010a; Wilder, 2013). While participants in this study disliked such policies and workers perceived them to be barriers, these rules did not prevent participants from utilizing shelters. In addition, participants in this study indicated that the availability of daytime services seemed to fill most of the gap created by such policies.

Wong, Park, and Nemon (2006) found that an additional barrier to accessing shelter was restrictive admissions policies barring individuals exhibiting severe symptoms of mental illness. However, homeless adult participants in this study, all of whom had an SPMI diagnosis, did not endorse this viewpoint. Though this may initially seem unexpected, it is important to remember that all of this study's participants were recruited from a drop-in center whose policies required users to be under the care of a mental health professional in order to become a member. As such, all participants in this study were likely receiving mental health care, which helped to moderate symptoms that might otherwise have barred them from accessing shelters.

One theory underlying this study was that there are an inadequate number of shelter beds available to accommodate the homeless population, resulting in some being turned away from shelters. No support for this theory was found, which is contrary to the literature. According to the literature, homeless adults are more likely to turn to shelters to escape the cold when temperatures drop in the wintertime, which results in shelters being unable to accommodate the increased demand for shelter (Donley & Wright, 2012; NCH, 2010b). Considering that this study occurred in the wintertime, when the weather was colder and would presumably push more homeless individuals to seek shelter beds, the lack of support for this theory may seem surprising at first glance. However, the participants in this study seemed to use shelters often, and as a result, were well versed in what time they needed to arrive at shelters to secure a bed. This may have increased their likelihood of securing shelter despite increased demands for shelter. In addition, Minnesota has more shelter beds available in the wintertime, which would presumably accommodate some of the increased demand for beds during this time of year. Minnesota also experienced a milder winter in comparison to past years, which likely contributed to less of a demand for shelter beds.

Another theory underlying this study was that unsheltered homeless adults do not use homeless shelters due to fears for their safety. No support for this theory was found. While safety risks were found to exist at shelters, the risks of being on the street seemed to outweigh shelter safety issues for most respondents. Further, shelter safety risks could not accurately be described as a barrier to shelter utilization, as safety risks clearly did not prevent homeless adults in this study from using shelters. Rather, safety was determined to be one of many decisional factors homeless adults weigh in deciding whether to use shelters and which shelters to use. Additional decisional factors including shelter location and

environment, shelter rules, and autonomy and dignity were also found to play a role in homeless adults' decisions on whether to use shelter. In light of these findings, a revised theory was developed. The revised theory is that homeless adults make the decision on whether to use shelters by considering and weighing the risks and rewards of a variety of factors, and there is usually a tradeoff that requires the homeless adult to sacrifice or lose something in exchange for receiving shelter.

Homeless adults' decisions to utilize shelter clearly involved considering a risk and reward balance in which tradeoffs were inherent. Homeless adult respondents utilized shelters to escape the stress and dangers of the streets and to receive protection from the elements; however, there was a cost. In exchange for safer shelter, homeless adults were put into the position of sacrificing their time to wait in line at shelters, losing some autonomy in order to abide by shelter rules, and risking deterioration of dignity. In other words, the reward of safer shelter was not without some risks. Homeless adults differed in terms of what sacrifices they were willing to make or which risks they were willing to accept in order to secure shelter, illustrating that the weight given to decisional factors was different for each individual.

Safety considerations seemed to carry the most weight in homeless adults' determination on whether to use shelter and on which shelters to use. This is not surprising considering Maslow's Hierarchy of Needs, which sets forth that lower-order needs, such as physiological and safety needs, must be satisfied before higher-order needs, such as esteem. It would make sense then that obtaining the safest shelter would be more important to homeless adults than sacrificing autonomy and dignity, and this was found to be the case for most participants. However, not all respondents placed the same emphasis on safety, again

illustrating the individualized nature of decisional factors. Autonomy and dignity seemed to be a more important factor for at least one homeless adult who, though he felt the streets were less safe than shelter, preferred shelter alternatives because he could control his own environment and felt sleeping near other shelter users who did not bathe violated his dignity.

Homeless adults' decisions on whether to use shelter alternatives were also fraught with tradeoffs, or more accurately, transactions. Again, safety issues were considered; however, the need to escape the streets often took such precedence that desperate homeless adults stayed with virtual strangers. Homeless adults often conducted financial transactions to secure couch-hopping arrangements, essentially purchasing shelter in the residence of others. Clearly these transactions were not always considered by the second party to be complete, as is evidenced by Angela's experience of being sexually assaulted and other respondents' experiences with having money and property stolen during couch-hopping arrangements. In such cases, these respondents were forced into another decision on whether to remain in the current environment or return to the streets.

Decisional factors seemed to play a role in homeless adults' utilization of additional, daytime services. Though decisional factors played a role in which daytime services homeless adults used, these factors were not explicitly stated. The findings illustrated that treatment by providers and positive experiences may be decisional factors weighed in determining use of daytime services. Homeless adults also seemed to assess their personal needs before engaging in services, and then selected services that would directly meet these needs.

Implications for Practice

There is limited research examining why some homeless adults choose not to use

emergency homeless shelters. Examining the perspectives of both professionals who work with the homeless and homeless adults themselves provided valuable data that can be used to better understand what factors play a role in homeless adults' decisions to utilize shelters. Service providers typically speak in terms of barriers; however, this study illustrates a lot of barriers perceived to exist by service providers are not true barriers in that they do not prevent some homeless adults' from using shelters. Rather, factors typically considered to be barriers were found in this study to be decisional factors homeless adults weight as they decide which services to use. An understanding of the tradeoffs homeless adults must make in order to utilize shelter and other services is necessary, because by asking homeless adults to utilize shelters, service providers are asking them to make these tradeoffs. Increased understanding of the difficulty surrounding a homeless adult's decision to utilize shelters should increase understanding of some homeless adults' resistance to using shelter and should increase empathy and understanding of service providers.

The cost-benefit analysis involved in weighing these decisional factors supports the need for service providers and shelters to understand the role dignity and autonomy play in homeless adults' usage of services. Respondents' reports that they were more likely to revisit shelters and utilize other services when they had a previous positive experience clearly illustrates that the validation of dignity is an important contributor to the perception of a positive experience. Service providers and shelters should use this knowledge to support the delivery of good customer service to shelter guests and service users. Not only will this offer the dignity validating positive experience homeless adults seek, but it will also encourage homeless adults to utilize shelters and other services that can keep them safe, meet basic needs, and assist them with exiting homelessness.

Respondents need for autonomy to be respected and to be treated as human beings seemed not to be understood and acknowledged by some shelters workers and other service providers, which is unfortunate. Mistreatment of homeless adults by shelter workers and other service providers encourages homeless adults to isolate themselves or to utilize risky shelter alternatives in order to avoid stigmatization. Stigmatization further damages dignity and self-esteem and leads to further marginalization of homeless adults, and this, combined with the resultant isolation, limits homeless adults' access to much needed services including housing, employment, and medical services.

On a macro level, the findings of this research illustrate many opportunities for service providers to increase advocacy efforts on behalf of homeless adults. In addition to continuing and increasing efforts to prevent and end homelessness, service providers must also be mindful of and seek out opportunities to advocate on behalf of individual clients. The example a worker provided of a transgender adult who was not allowed to move floors in a shelter because she did not have the proper id is one illustration of an opportunity to advocate on behalf of a homeless adult client. Workers knowledgeable about housing program policies and HUD guidelines that serve as barriers to homeless adults obtaining permanent housing are in the position to work for systematic change to such guidelines and policies. In addition, there is a need for service providers to advocate for funding for affordable housing in order to increase the availability of affordable housing options, which will assist with meeting the current demand.

Service providers should also consider engaging homeless adults in advocating on their own behalf, which will provide an opportunity for their voices to be heard and in turn validates dignity. My experience conducting interviews with homeless adults illustrated to

me the importance of homeless adults having an outlet to tell their stories. After only a few minutes of introductions at the beginning of the interviews, I found that homeless adult respondents were surprisingly candid and open regarding their life stories and their lived experiences. In addition, at least half of the participants thanked me for listening to their stories and caring about their plight. Not only did respondents seem grateful for the opportunity to be heard, but they also expressed hope that telling their stories would serve to assist other homeless individuals. This willingness to help others could be channeled into advocacy opportunities.

Implications for Policy

The findings of this study illustrate a need for shelters to examine their rules and policies. One homeless adult respondent's issue with shelter users being expected to abide by safety rules regarding bag checks while workers were not subjected to the same rules, calls for examination of what other rules are different for shelter workers and how and why these rules are different. Such discrepancies result in violations to shelter users' dignity, because they lead to the perception that shelter users are less than workers. While shelter rules are important to maintain order, consistent enforcement of these rules is necessary not only to increase feelings of safety, but also to eliminate shelter users' perceptions that some individuals are favored over others. In addition, rules should be clearly stated in order to ensure understanding by all shelter users and workers, and wherever possible, rules should not be punitive. This would assist with consistent enforcement of the rules, and shelter users' clear understanding of the rules could contribute to an environment in which they take responsibility for upholding the rules and assisting others with understanding and upholding them as well. This could create a self-governing environment in which shelter users would

feel increased autonomy.

Increased attention to enforcing sobriety rules at shelters with sobriety requirements would increase feelings of safety for some shelter users. Alternatively, there is a clear need for the availability of shelters operating under a harm reduction approach in order for homeless adults with substance use disorders to obtain safe shelter. As with sobriety rules, rules geared towards a particular subset of the homeless population should be evaluated to determine whether they serve as barriers. Examples of such rules found in this study were those pertaining to gender segregation, which negatively impacted transgender shelter users, and curfew rules that bar shelter users who work non-traditional schedules from obtaining safe shelter in which to sleep.

Homeless adults in this study highlighted a need for the expansion of weekend services to provide a safe place for homeless adults to spend daytime hours during the weekend. Basic needs services such as meals, shower and laundry facilities, and bathrooms are a daily necessity of homeless adults and thus are still needed on the weekend. Provision of daytime weekend services could decrease the likelihood that homeless adults would incur criminal charges for homeless crimes, such as loitering, for utilizing restaurants and retail establishments as temporary shelter from the dangers and stresses of the streets and to escape inclement weather conditions.

Both respondents and workers in this study reported that lack of affordable housing is a barrier to exiting homelessness. Respondents complained of long waits for affordable housing, and both respondents and workers found market rate rents to be unaffordable for most homeless adults. Homeless adults encountering long waiting lists for affordable housing have no choice but to continue to utilize shelters or shelter alternatives, and the lack of

structure and consistency presented by trying to survive on a day-to-day basis made it difficult for some homeless adults to stay in contact with housing workers in order to maintain their spot on affordable housing waiting lists. There is a definite need in Minnesota for more affordable housing options.

HUD requirements and some GRH funding policies are restrictive and serve as barriers to obtaining permanent housing and exiting homelessness, which validates findings in the literature. The findings of this study revealed that couch-hopping arrangements are the shelter alternatives most often used by homeless adults. However, according to HUD standards, couch-hopping is not considered an episode of homelessness. Perhaps policymakers presume couch-hopping arrangements are safer than shelter alternatives not meant for habitation, and thus more priority is given to those using such alternatives; however, the results of this study do not endorse this viewpoint, as couch-hopping arrangements were often fraught with risks. In this light, it is unconscionable that homeless adults utilizing these risky alternatives would not be considered homeless according to the guidelines for some housing programs.

Workers in this study believed that HUD, GRH, and other housing programs would be more accessible to homeless adults if there were more access points to these housing options besides having to utilize shelters and if there were more ways to prove homelessness. This finding is worth consideration by policymakers, as service providers who work with the homeless population are equipped to make determinations of homelessness based on a number of factors, including length of homelessness and shelter alternatives the homeless individual has used. Workers also identified the need for policymakers to be informed of how policies will actually impact the people they are meant to serve. Policymakers need to be

open to listening to service providers who work with the homeless population and homeless individuals themselves in order to truly understand the impact of policies, including what the needs are and how to address them in a productive and helpful way, rather than in a way that creates additional or undue barriers.

Implications for Research

This study found a few decisional factors that homeless adults weigh when trying to decide whether to use shelters and which shelters to use. Future research should focus on identifying additional decisional factors that may play a role in homeless adults' decisions on using shelters and other services. The findings of this study indicate that the emphasis placed on decisional factors may vary among individuals, but certain factors, such as safety, may be weighed similarly. An examination of the relative importance of each decisional factor, or the weight each factor carries in the cost-benefit analysis, would lend insight into homeless adults' limits on what tradeoffs they are willing to make in exchange for shelter or when utilizing other services.

Strengths and Limitations

Non-whites were overrepresented in this study's sample. According to data provided by Wilder (2013), 55% of homeless adults are African American, American Indian, and Hispanic. The sample for this study was 83% African American and African American and American Indian. Men were also represented in this sample, as men make up about 53% of the homeless population (Wilder, 2013), but 83% of the participants for this study were male. One likely reason for this is that men in the 22-54 age range are most likely to be homeless, followed by women in the same age range (Wilder, 2013); all participants for this study fell into this age range. All study participants reported having an SPMI diagnosis, making adults

with mental illness overrepresented in this sample, as 60% of Minnesota adults experiencing long-term homelessness have a serious mental illness (Wilder, 2013). I hesitate to say that the overrepresentation of homeless minorities and homeless adults with mental illness was a limitation of this study, as these vulnerable populations are usually so underrepresented.

A benefit of the focus group methodology is that it allows for the collection of a larger amount of data in a shorter amount of time than individual interviews. The utilization of a convenience sample of workers who have experience working with the homeless population yielded relevant insights on the utilization of homeless shelters by homeless adults. In terms of individual interviews, this experience was mutually beneficial to both the respondent and the interviewer, as half of the respondents expressed gratitude for the opportunity to tell their stories and share their experiences and appreciation of being listened to, heard, and understood. Triangulation of data from both workers and homeless individuals offered a more comprehensive picture of perspectives of shelter utilization by homeless adults, and findings from each source were confirmed or corroborated by the other, increasing the reliability of the data.

As was previously mentioned, one limitation of the focus group method of data collection is that the researcher could not fully control breaches of confidentiality. Recruitment of homeless individuals was challenging, as unsheltered homeless adults can be difficult to find, are isolated, and often prefer to be left alone. The small sample size for this study limits the generalizability of findings. Respondent bias may have been present, particularly in the focus group setting, where respondents might have withheld information in order to protect their privacy or might have offered answers they believed the researcher or others wanted to hear. The recruitment of workers from a meeting in which they discuss

similar issues to those addressed in the focus group questions, and the recruitment of workers from the same organization, is expected to have reduced respondent bias.

In conclusion, shelter utilization by homeless adults is a far more complex issue than their ability and willingness to access emergency shelters. Homeless adults utilize shelters out of necessity in order to escape the stresses and dangers of the streets and to seek cover from inclement weather. Homeless adults also utilize a variety of shelter alternatives that put them at risks for victimization. In addition, homeless adults without shelter are at increased risk of committing or being charged for crimes and acute and chronic health issues. Homeless adults utilize a variety of services in addition to shelters in order to meet both short- and long-term needs, and they are more likely to utilize services when they have had a previous positive experience.

Safety issues at shelter and shelter capacity were found not to be true barriers to shelter use, since they did not prevent some homeless adults from utilizing shelters. A variety of factors were found to play a role in homeless adults' decisions to utilize shelters including the safety of shelter versus safety of the streets, the shelter location and environment, shelter rules, and autonomy and dignity. The emphasis placed on each of these factors varies among individuals. Barriers to exiting homelessness include lack of affordable housing, market rate rental requirements, legislative and housing policies, and a combination of additional factors. Implications for practice and policy include a need for service providers to understand the tradeoff they are asking homeless adults to make in order to use shelters, the role dignity and autonomy play in service utilization, the need for increased advocacy efforts on behalf of the homeless population, examination of shelter policies and rules, more affordable housing, and increased access to affordable housing.

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Appendix A

Worker Recruitment Statement

My name is Michelle Sveiven Smith, and I am a graduate student at St. Catherine University. I am seeking workers who have one year or more experience in direct, non-administrative practice with homeless individuals to participate in a research study I'm conducting in partial fulfillment of requirements for an MSW degree.

The purpose of the study is to examine the perspectives of individuals who work with the homeless regarding barriers to shelter usage of homeless adults. I will be conducting two or three focus groups in the next one to two months and am seeking four to six individuals to participate in each group. Groups will be held at human services agencies in Minneapolis, and each group is expected to last one to two hours.

If you are interested in participating in a focus group, please contact me at 612-329-5797 or smit6948@stthomas.edu to receive an invitation to focus groups. Invitations will be sent once focus group dates, times, and locations are set and will ask that you select the date and time that work best for you and email me with an RSVP to which group you'd like to attend.

Appendix B

Worker Recruitment Flyer

Are you a worker who has at least one year of experience in direct, non-administrative practice with homeless individuals?

If so, please consider participating in a research study.

Purpose

The purpose of the study is to examine the perspectives of individuals who work with the homeless regarding barriers to shelter usage of homeless adults.

Details

I will be conducting two or three focus groups in January, which each are expected to last between one and two hours. I am seeking four to six individuals to participate in each group.

Contact Information

If you are interested in participating in a focus group, please contact **Michelle Smith** at **612-329-5797** or **smit6948@stthomas.edu** to receive an invitation to focus groups. Invitations will be sent once focus group dates, times, and locations are set and will ask that you select the date and time that work best for you and email me with an RSVP to which group you'd like to attend.

I look forward to hearing from you!

Appendix C

Focus Group Invitation Email

You are receiving this email because you expressed interest in participating in a focus group for my research study examining worker perspectives on homeless adults' usage of homeless shelters. I have scheduled two focus groups. The date, time, and location for each group is provided below. Please RSVP as soon as possible with which group you plan to attend. If you have any coworkers who may be interested in participating who also have at least one year of direct practice (non-administrative) experience working with the homeless, please forward this email to them or bring them along to the group with you. If you no longer wish to attend a focus group, please disregard this email. You **must RSVP by January 22, 2015** in order to participate in a focus group. If you have any questions, please let me know.

Thank you,
Michelle Sveiven Smith

Group 1

Date: Friday, January 23, 2015

Time: 3 p.m. to 4:30 p.m.

Location: Franklin Library, Friends of Franklin Community Room (Lower Level of Library), 1314 E. Franklin Ave., Minneapolis, MN 55404

Group 2

Date: Friday, January 30, 2015

Time: 12 p.m. to 1:30 p.m.

Location: Franklin Library, Friends of Franklin Community Room (Lower Level of Library), 1314 E. Franklin Ave., Minneapolis, MN 55404

Appendix D

Homeless Individual Interview Recruitment Statement

My name is Michelle Sveiven Smith, and I am a graduate student at St. Catherine University. I am looking for homeless adults who are 18 or older, long-term homeless, and currently living somewhere that is not a homeless shelter to participate in a research study I'm conducting in partial fulfillment of requirements for an MSW degree.

The purpose of the study is to look at why some homeless individuals do not use homeless shelters.

If you decide to participate, you will be asked to complete an individual interview with me. This interview will be audio recorded and may later be typed word for word by a transcriptionist in order to provide me with a record of the interview. This interview is expected to take 45 to 60 minutes. Alternatively, if you would prefer to fill out the survey on your own instead of participating in an interview, you may do that as well. I can either give you the questions, and you may take them and write in your answers, or I can read you the questions and you can write down your answers.

As thanks for your participation, you will receive a \$10 bus pass. The incentive you choose will be provided before the interview starts.

Appendix E

**WORKER AND HOMELESS INDIVIDUAL PERSPECTIVES ON EMERGENCY SHELTER
USAGE
INFORMATION AND CONSENT FORM****Introduction:**

You are invited to participate in a research study investigating the usage of homeless shelters by homeless adults, age 18 and older, in Minneapolis, Minnesota. This study is being conducted by Michelle Sveiven Smith, a graduate student at St. Catherine University under the supervision of Lisa Kiesel, Ph.D., a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you have one year or more experience in direct, non-administrative, or outreach practice with homeless individuals. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to examine the perspective of individuals who work with the homeless regarding shelter usage of homeless individuals. Approximately 18 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to attend and participate in a semi-structured focus group to engage in a discussion on shelter usage by homeless individuals. Focus groups will convene at RESOURCE Chemical and Mental Health or St. Stephen's Human Services, both located in South Minneapolis. Michelle Smith will moderate the focus group and will have prepared questions she asks to encourage discussion. The focus group proceedings will be audio recorded and transcribed verbatim. This study will take approximately two hours over one session.

Risks and Benefits of being in the study:

This study has minimal risk. Participants may experience an inconvenience in the form of the two hour time commitment necessary for participation. Though I will encourage group members to keep each other's comments confidential, it is impossible for me to promise that none of a participant's comments will be repeated outside of the group. As such, you may experience some discomfort answering certain questions, in which case, I encourage you to participate at the level you're comfortable. There are no direct benefits to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the audio recordings of focus group session in a password-protected file on my personal computer and only Dr. Kiesel and I will have access to the records while I work on this project. A transcription service may be utilized to produce verbatim transcription of the audio files, in which case the transcriber will be asked to sign a confidentiality agreement to ensure protection of your information. I will destroy all audio recordings, transcripts, and identifying information that can be linked back to you on or after May 24, 2015.

Voluntary nature of the study:

Participation in this research study is voluntary. You may choose not to answer certain questions during your participation in a focus group. Your decision whether or not to participate will not affect your future relations with your employer, RESOURCE Chemical and Mental Health, St. Stephen's Human Services, community human services agencies, community shelters, or St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Michelle Sveiven Smith, at (651) 329-5797 or smit6948@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Lisa Kiesel, Ph.D., (612) 963-3767 or kies0954@stthomas.edu, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

I consent to participate in the study. I agree to be audio recorded.

Signature of Participant

Date

Signature of Researcher

Date

Appendix F

Transcription Services

Confidentiality Agreement

I, Robin Kasten, transcriptionist, agree to maintain full

confidentiality in regards to any and all audio files received

from Michelle Smith related to her research

study. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-recorded discussions, or in any associated documents;
2. To not disclose any information received for profit, gain, or otherwise;
3. To not make copies of any audio or computerized files of the transcribed interview text;
4. To store all study-related audio files and materials in a safe, secure location as long as they are in my possession;
5. To return all study-related materials to _____ in a complete and timely manner.
6. To delete all electronic files containing study-related audio files and documents from my computer hard drive and any backup devices upon completion of delivery of transcripts.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes, videotapes and/or paper files to which I will have access.

Transcriber name: Robin L. Kasten

Transcriber signature: Robin L. Kasten

Date: 2/12/15

Appendix G

**WORKER AND HOMELESS INDIVIDUAL PERSPECTIVES ON EMERGENCY SHELTER
USAGE
INDIVIDUAL PARTICIPANT CONFIDENTIALITY SCRIPT****Introduction:**

You are being asked to participate in a research study examining the use of homeless shelters by homeless adults, age 18 and older, in Minneapolis, Minnesota. My name is Michelle Sveiven Smith, and I am a graduate student at St. Catherine University. I am conducting this research under the supervision of Lisa Kiesel, Ph.D., a faculty member in the Department of Social Work. You were selected to participate in this research because you are an adult who is currently homeless or who has previously experienced long-term homelessness.

Background and procedures:

I am conducting this study to look at why some homeless individuals do not use homeless shelters. If you decide to participate, you will be asked to complete an individual interview. This interview will be audio recorded to provide me with a record of this interview. This interview is expected to take 45 to 60 minutes.

Risks and Benefits of being in the study:

Discussing your experience of homelessness may be difficult and may result in some discomfort. Some bad memories may be triggered during our discussion. If this is the case, you may stop the interview at any time. I would also encourage you to discuss your feelings with your current workers. If you aren't comfortable asking your worker for help, some free resources are listed on the back of this form.

As thanks for your participation, you will receive a \$10 bus pass or a meal up to \$10 in value at the restaurant where we meet. You will choose which incentive you'd like to receive. The incentive you choose will be provided before the interview starts.

Confidentiality:

The information you provide, your identity, and your involvement in this study will be kept confidential. Your identity will not be presented in any written report or presentation of this information. I will keep the audio recording on a password-protected computer. Only Dr. Kiesel and I will have access to the information while I work on this project. The audio recording may be typed word for word by a transcriptionist who will be asked to sign an agreement to protect your information. I will destroy the audio files and the transcript of our interview on or after May 24, 2015.

Voluntary nature of the study:

Participation in this research study is voluntary. You may choose not to answer some questions during our interview. Your decision whether or not to participate will not affect your future relations with any of your service providers, workers, community homeless shelters, or St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships. Do you feel pressured in any way to complete this interview?

Contacts and questions:

If you have any questions, please contact me, Michelle Sveiven Smith, at (651) 329-5797 or smit6948@stthomas.edu. If you have any additional questions later, the faculty advisor, Lisa Kiesel, Ph.D., (612) 963-3767 or kies0954@

stthomas.edu, will be happy to answer them. If you have other questions or concerns about the study and would like to talk to someone besides the researcher, you may contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

Do you have any questions about completing this interview with me today? You may keep a copy of this form for your records.

Consent:

Do you agree to complete this interview and to be audio recorded while doing so?

Signature of Researcher

Date

FREE RESOURCE LIST

OutreachSt. Stephen's Street Outreach

612-879-7624

or free from any payphone: 1-888-550-7624

Central Lutheran Church

333 South 12th St.

(Drop-in hours M-F from 9 to 11 a.m.)

You do NOT need to be sober to access services, which include: advocacy, shelter, outside gear/emergency needs, medical/dental care, chemical/mental health)

Adult shelterSalvation Army Harbor Light

612-767-3113

1010 Currie Avenue North

(Also provides showers & meals, 8am-8pm)

Catholic Charities Higher Ground

612-204-8552

165 Glenwood Avenue

(For men. Opens at 5pm.)

Simpson Women's Shelter

612-871-1138 2740

1st Avenue South

(Lottery for available beds is held **Wednesdays at 3:30 pm**. Arrive between 3:00 and 3:30. Can also call nightly after 5pm to see if there are openings.)

Lottery for available men's beds at the shelters below is held at Simpson Shelter every Monday at 6pm.

****Must be sober at time of lottery.****

Simpson Men's Shelter

612-874-0306

2740 1st Avenue South (Call after 5pm.)

St. Stephen's Men's Shelter

612-874-9292

2211 Clinton Avenue South (Call after 3pm.)

Our Saviour's Shelter

2219 Chicago Avenue South

612-872-4193

(Serves men & women, call after 6pm.)

Drop-InsCatholic Charities Opportunity Center

612-204-8300

740 East 17th St. (17th & Chicago)

Showers, laundry, health care, employment programs, breakfast (7 to 8 am); lunch (11:30 am to 12:30 pm)

Building Hours: summer Mon-Sat from 7 am to 3 pm;
winter Mon-Sat from 7 am to 4 pm.

Free Meals & ShowersLoaves & Fishes (612-871-2981)

2123 Clinton Avenue South

Dinner: M-F 5:30 to 6:30 pm.House of Charity (612-594-2000)

510 South 8th Street

Meals: M-F women & children only 8-8:30am; M-F everyone 12-1pm; Sat/Sun, everyone 10:30-11:30 am.

Showers: Mon-Fri 9-10 am.**Battered Women**Tubman Crisis (612-825-0000)

3111 1st Avenue South (Singles, families, victims of prostitution & domestic abuse)

PRIDE Crisis: (612-728-2062)

4123 East Lake Street (Serves victims of sex trafficking and sex exploitation)

Rape & Sexual Violence Hotline (612-825-HELP)**Clothing**Sharing & Caring Hands (612-338-4640)

525 North 7th Street

(M-Th 10-11:30am & 1:30-3:30pm; Sat/Sun 9:30-10:30 am)

Physical & Mental Health Care

Health Care for the Homeless 612-348-5553 Clinics are in 11 Minneapolis shelters/drop-in centers. *Hours:* Mon-Fri at varying sites (call for locations and hours). No insurance or appointments required to receive care.

Clinic sites: Adult Opportunity Center, Harbor Light, Harriet Tubman, Higher Ground, Mary's Place, People Serving People, Public Health Clinic, Sharing and Caring Hands, Simpson Shelter, St. Stephen's Shelter, Youthlink

Hennepin Co. Medical Center

Suicidal: 612-873-2222 **Consultation:** 612-873-3161 701 Park Avenue South (24/7 Crisis Intervention)

Crisis Connection 1-866-379-6363Walk-in Counseling Center 612-870-0565

2421 Chicago Ave S

Hours: M, W, F from 1-3pm; M, W 6:30-8:30pm

Appendix H

Focus Group Questions

1. Please introduce yourself stating your name and, if you feel comfortable sharing, how long you've worked with the homeless, in what capacity, and a brief summary of your current work with the homeless.
2. Why do you think some homeless adults don't utilize homeless shelters?
3. What risks do you think the individual encounters as a result of not utilizing shelter?
4. What do you see as barriers to accessing homeless shelters or other services?
5. What role do you think perceptions of safety play in shelter utilization?
6. Can you give examples of shelter policies or rules that you think may encourage or inhibit shelter utilization?
7. Does anyone have any final thoughts regarding shelter utilization among homeless adults?

Appendix I

Individual Interview Questions**Demographic**

1. How old are you?
2. What gender do you identify with?
3. What racial or ethnic group do you identify with?
4. What type of place did you sleep at last night:
☐ Homeless Shelter ☐ Family or friend's house ☐ Camp alone ☐ Camp with others
☐ Car or other vehicle ☐ Other (please describe):

History of Homelessness

5. How long have you been homeless?
6. What would you say is the number one reason you are currently homeless?
7. What is the longest amount of time you have been without a permanent place to live?
8. How many times have you experienced homelessness throughout your life?

Shelter/Service Utilization

9. Have you ever used a homeless shelter before?
 - 9a. If yes, please describe your experience at the shelter (e.g., tell me about the environment, how you felt being at the shelter, what services were provided, what workers and other shelter users were like, etc.). Would you use a shelter again? Why or why not?
 - 9b. What were the benefits to using the shelter?

- 9b. If no, would you use a homeless shelter? Why or why not?
10. What are some services you have used while homeless?
- 10a. Which services have been most helpful and why?
- 10b. Which services have been least helpful and why?

Homeless Experience

11. Where do you typically sleep at night?
- ☐ Homeless Shelter ☐ Family or friend's house ☐ Camp alone ☐ Camp with others
- ☐ Car or other vehicle ☐ Other (please describe):
-
12. Have you been the victim of a crime while homeless, and if so, can you tell me about that experience (e.g. describe what happened and how you dealt with it)?
13. Have you ever slept outside, in a camp, in a car, or somewhere else not typically used for sleeping?
- 13a. If yes, why did you decide to sleep there?
- 13b. Please tell me about this experience (e.g. Why did you decide to camp/sleep in a car? Were you with others or alone? Did you feel safe/unsafe, hot/cold, etc.?).
- 13c. What other risks do you encounter by not using shelters?
14. Where do you spend your time during the day?